

Hospital Prereview Questionnaire (I-PRQ)

Level II Pediatric Trauma Center | Children Only

**IMPORTANT INFORMATION:**

* **Use this document to gather the hospital data. There may be some variation between this document and the online PRQ.**
  + **Do not enter N/A or NA in any fields, leave blank.**
* **The clarification document, previously known as the frequently asked questions (FAQ), and the Verification Change Log must be used in conjunction with the Resources manual,** [**www.facs.org/quality-programs/trauma/vrc/resources**](http://www.facs.org/quality-programs/trauma/vrc/resources)**.**

* + **The clarification document contains clarification to criteria noted in the resources manual.**
  + **The Verification Change Log contains changes made to the requirements from the publication date.**
* **Reporting period is defined as 12 months with a 2 month lag from the date of the site visit. Data cannot be older than 14 months prior to the site visit.**
* **The online version of the I-PRQ will be released and access provided upon receipt of your site visit application.**
* **This document cannot be submitted in lieu of the online I-PRQ.**
* **Adult and Pediatric Data:**
  + **For centers seeking a Level I adult and a Level I pediatric consultation/verification, separate online PRQs will be provided. The adult and pediatric data MUST be entered separately into each assigned PRQ.**
  + **For all other visits that admit adult and pediatric patients, the tables in Chapter 2 should include the adult and pediatric data. In Chapter 10, ONLY answer section A, question 1; section B. Splenic Injury table, and all of section C with only pediatric data that relates to your facility, then go to XI. Collaborative Services.**
* **All trauma centers must use a risk–adjusted benchmarking system to measure performance and outcomes (CD 15-5).**

**Effective for visits scheduled after August 1, 2018: Participation in TQIP best meets this requirement. Other risk-adjusted benchmarking programs will be considered and must include the components outlined in the** [**CD 15-5 Requirements and Rationale document**](https://www.facs.org/~/media/files/quality%20programs/trauma/CD_15_5_Reqs_Rationale.ashx)**,** [**https://www.facs.org/~/media/files/quality%20programs/trauma/CD\_15\_5\_Reqs\_Rationale.ashx**](https://www.facs.org/~/media/files/quality%20programs/trauma/CD_15_5_Reqs_Rationale.ashx)

**Verified centers that are both an adult Level I or II and pediatric Level I must participate in both an adult and a pediatric risk-adjusted benchmarking program in order to meet CD 15-5. Centers that are verified as both an adult Level I or II and pediatric Level II must only participate in an adult risk-adjusted benchmarking program in order to meet the criteria.**

* **The data collected in the online I-PRQ may be used for analysis by the ACS Committee on Trauma. All hospital identifiers will be removed and will not be included in the analysis.**
* **Questions that have L1, L2, L3 followed by a CD#, refers to the criteria that must be in compliance with the level being surveyed. The online PRQ should only display questions relevant to the level of your trauma center; therefore, you may see numbers and questions that have been skipped. We ask that if you see questions that do not pertain to your level to submit a screen shot or email to** [**COTVRC@facs.org**](mailto:COTVRC@facs.org)**.**

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**PURPOSE OF SITE REVIEW**

Type of Review:

1. Consultation
2. Verification
3. Reverification

Level of Review:

Level II Pediatric Trauma Center**\* if this changes, please contact the VRC office\*\***

Facility treats what type of patients:

Children Only

This review is at the request of:

1. Individual Hospital
2. Designating Agency
3. Both
4. Other

Reporting year for this review (12 months and should not be older than 14 months)

From month/year:

To month/year:

The designating agency for the trauma center is:

1. None
2. County
3. Region
4. State

Name:

Date of most recent review (mm/yyyy): (consultation, focused, verification or reverification) \*If the last review performed by ACS was a consultation review, that is the most recent review.

If verified, date of verification:

Reviewer's Names:

Most recent review by ACS was for:

1. Verification
2. Reverification
3. Focus
4. Consultation

Level of trauma center for most recent review by ACS:

1. Level I Trauma Center
2. Level II Trauma Center
3. Level III Trauma Center
4. Level I Pediatric Trauma Center
5. Level II Pediatric Trauma Center
6. Level I Trauma Center and Level II Pediatric Trauma Center
7. Level II Trauma Center and Level II Pediatric Trauma Center

Last verification was for (type):

1. Adults Only
2. Children Only
3. Adults and Children

Number of deficiencies cited at the last review (consultation, verification, reverification or not the focused review).

* Briefly list any deficiencies and how they were corrected (list by bullets or numbered points):

Number of weaknesses found at last review:

* Briefly list any weaknesses and how they were addressed (list by bullets or numbered points):

Describe any program changes (Administrative) that have occurred since the last review:

**HOSPITAL INFORMATION**

**A. General Information**

1. Tax Status:

1. Profit
2. Non-profit
3. Government

2. Is there a Medical School Affiliation? (Yes/No)

If yes, Name:

**B. What is the hospital Payer Mix (use whole numbers, do not include percent sign):**

|  |  |  |
| --- | --- | --- |
| Payer | All Patients (%) | Trauma Patients (%) |
| Commercial |  |  |
| Medicare |  |  |
| Medicaid |  |  |
| HMO/PPO |  |  |
| Uncompensated/Indigent |  |  |
| Other |  |  |
| Total | 100% | 100% |

* Define Other:

**Note: Questions that have L1, L2, L3 followed by CD# - refers to the criteria number that must be met at the requesting trauma center (Level I, Level II, or Level III) as outlined in the *Resources for Optimal Care of the Injured Patient: 2014*. The online PRQ will only display questions relevant to the level of your trauma center.**

**C. Hospital Beds (do not include neonatal beds):**

|  |  |  |  |
| --- | --- | --- | --- |
| Hospital Beds | Adult | Pediatric | Total |
| Licensed |  |  |  |
| Staffed |  |  |  |
| Average Census |  |  |  |

**I. REGIONAL TRAUMA SYSTEMS: Optimal Elements, Integration, and Assessment**

1. Does the trauma center leadership participate actively in a state and regional system?  
    (CD 1­1, CD 1­2, CD 1­3) Type II / L1-4 (Yes/No)

* If ‘Yes’, please briefly describe:

**II. DESCRIPTION / TRAUMA LEVEL AND ROLES**

1. Does this trauma center have an integrated, concurrent performance improvement and patient (PIPS) program to ensure optimal care and continuous improvement in care? (CD 2-1) Type I / L1-4 (Yes/No)
2. Does the trauma center demonstrate surgical commitment? (CD 2-2) Type I / L1-3 (Yes/No)  
   * If ‘No’, please describe:
3. Does the trauma center provide the necessary human and physical resources (physical plant and equipment) to properly administer acute care consistent with their level of verification? (CD 2-3) Type II / L1-4 (Yes/No)

***If seeking a visit as a combined Level I or II adult with a Level II pediatric, only one PRQ will be provided. The tables in Chapter II should include the adult and pediatric statistical data. ONLY use pediatric statistical data in Chapter X and complete the entire section.***

***For all other centers that admit adult and pediatric patients, the tables in Chapter II should include the adult and pediatric statistical data combined. Then in Chapter X use pediatric statistical data ONLY to answer the following: Section A question 1; Section B-Splenic Injury Table, and all of section C.***

***For all other centers that admit ONLY adult patients, Chapter X will not be displayed.***

***For all other centers that admit ONLY pediatric patients, the data tables are split between Chapter II and Chapter X, and are not duplicated. In regard to the PICU, questions are split between the ICU section and PICU section, again questions are not duplicated.***

1. Complete the table below using the total number of emergency department (ED) trauma visits for the reporting year following the National Trauma Data Standard (NTDS) Trauma Inclusion Criteria.

|  |  |
| --- | --- |
|  | Total |
| Admitted ED Trauma Visits (Regardless of Service) |  |
| Blunt Trauma Percentage |  |
| Penetrating Trauma Percentage |  |
| Thermal Percentage |  |

6. Disposition ED Trauma Visits

|  |  |
| --- | --- |
| Discharged |  |
| Transferred Out |  |
| Admitted |  |
| DIED in the ED Excluding DOAs |  |
| DOAs |  |
| Total |  |

1. Total number of direct admissions:
2. Does the trauma director have responsibility and authority for determining each general surgeon’s ability to participate on the trauma panel based on an annual review through the trauma PIPS program and hospital policy? (CD 2-5) Type II / L1-3 (Yes/No)
3. Do trauma surgeons take in-house call? (Yes/No)

* Are there qualified attending surgeons who participate in major therapeutic decisions, are present in the emergency department for major resuscitations, present at operative procedures, and actively involved in the critical care of all seriously injured patients? (CD 2-6) Type I / L1-2 (Yes/No)
* **\* If PGY 4 or 5 are not utilized at your center, skip this question.\*** A resident in postgraduate year 4 or 5 or an attending emergency physician who is part of the trauma team may be approved to begin resuscitation while awaiting the arrival of the attending surgeon but cannot independently fulfill the responsibilities of, or substitute for, the attending surgeon. The presence of such a resident or attending emergency physician may allow the attending surgeon to take call from outside the hospital. In this case, are local criteria and a PIPS program established to define conditions requiring the attending surgeon’s immediate hospital presence? (CD 2-7) Type I / L 1-2 (Yes/No)
* Describe trauma surgeon coverage:

1. Percent of the time the attending trauma surgeon is present in the ED on patient arrival for the highest level of activation (15 minutes for Level I and II; for Level III 30 minutes).

Have data available at the time of the site visit as attachment 2-2.

1. Is the attending trauma surgeon’s presence in the emergency department threshold of 80% met for the highest-level of activation (15 minutes for Level I and II; 30 minutes for Level III)? (This includes responding for trauma patients who are subsequently transferred to another facility). (CD 2-8) Type I / L1-3 (Yes/No)
2. Is the trauma attending surgeon’s arrival (within 15 minutes (L1-2) / within 30 minutes (L3) for patients appropriately monitored by the hospital’s trauma PIPS program? (CD 2-9) Type I / L1-3 (Yes/No)
3. Is the trauma surgeon dedicated to the trauma center while on call? (CD 2-10) Type II / L1-3 (Yes/No)
4. Is there a published backup call schedule for the trauma surgeons? (CD 2-11, CD 6-6). Type II / L1-3 (Yes/No)
5. Does the facility participate in regional disaster management plans and exercises? (CD 2-22) Type II / L1-4 (Yes/No)

**III. PREHOSPITAL TRAUMA CARE**

1. Describe the area and identify the number and level of other trauma centers within a 50­mile radius of the hospital. Do not include the names of those facilities:

* Have a map of your referral area available at the time of the site visit as attachment 3­1.

1. Who has statutory oversight and licensure over EMS?
2. County
3. Region
4. State
5. Other (if other, briefly define):
6. Who establishes treatment protocols over EMS?
7. Briefly describe the air medical support services available for your trauma program, including roto­wing and fixed wing services:
8. Does your hospital provide on­line medical control for prehospital trauma patients? (Yes/No)

* If 'Yes', please briefly describe:

1. How does the trauma program participate in the training of prehospital personnel, the development and improvement of prehospital care protocols, and performance improvement and patient safety programs? (CD 3–1) Type II / L1­4
2. Describe how protocols that guide prehospital trauma care established by the trauma health care team, including surgeons, emergency physicians, medical directors for EMS agencies, and basic and advanced prehospital personnel: (CD 3-2) Type II / L1­4
3. Is the trauma director involved in the development of the trauma center’s bypass (divert) protocol? (CD 3–4) Type II / L1­3 (Yes/No)
4. Is the trauma surgeon involved in the bypass (divert) decision? (CD 3-5) Type II / L1­3 (Yes/No)
5. Was the trauma center on bypass (divert) less than 5 percent of the time during the reporting year? (CD 3-6) Type II / L1­3 (Yes/No)

* Please complete Bypass (Divert) Appendix #3.

1. When the trauma center is required to go on bypass or to divert, what is your process? (CD 3-7) Type II / L1­4

**IV. INTERHOSPITAL TRANSFER**

1. Does your facility have a set of criteria that identifies patients who should be considered to be transferred out of your facility? (CD 4-2) Type II / L1-4 (Yes/No)

* If ‘Yes’, please describe:

1. Is there direct physician-to-physician or midlevel contact when patients are transferred out of your facility? (CD 4-1) Type II / L1-4 (Yes/No)

* If ‘Yes’, how is this contact initiated and documented?

Is there direct physician-to-physician or midlevel contact when patients are transferred into your facility? (Yes/No)

* If ‘Yes’, how is this contact initiated and documented?

1. Does your trauma service routinely evaluate all transfers through the PIPS program? (CD 4-3, CD 16-8) Type II / L1-4 (Yes/No)  
     
   ***For further clarification, refer to Chapter 16 in the Resources Manual.***

* If ‘Yes’, please describe the process:

1. Total number of transfers:   
   *Please complete the table below. The total of transfers in column 2 + column 3 in the table should = the total number of transfers out.*

|  |  |  |
| --- | --- | --- |
| Transfer Category | Number of transfers out < 24 hrs | Number of transfers out > 24 hrs |
| Pediatrics |  |  |
| Hand |  |  |
| Spine |  |  |
| Orthopaedics\* | | |
| Pelvic ring/acetabular fxs |  |  |
| Soft tissue coverage |  |  |
| Other orthopaedics |  |  |
| Neurosurgery\* |  |  |
| Replantation |  |  |
| Vascular/aortic injuries |  |  |
| Cardiac (Bypass) |  |  |
| Facial trauma |  |  |
| Health Plan Repatriation |  |  |
| Burns |  |  |
| Other-Specify |  |  |
| Total |  |  |

***\*Orthopaedics and neurosurgery categories should exclude hand and spine injuries.***

6. What is your benchmark for the length of time between patient arrival, decision to transfer, and patient departure?

7. Is this parameter tracked as a part of the PIPS process? (Yes/No)

**V. HOSPITAL ORGANIZATION AND THE TRAUMA PROGRAM**

**A. Hospital Commitment**

1. Does the hospital have the commitment of the institutional governing body and medical staff to become a trauma center? (CD 5-1) Type I / L1­4 (Yes/No)  
    ***For further clarification, refer to Chapter 16 in the Resources Manual.***

* Please have resolutions available at the time of the site visit as attachment 5­1.

1. Is the administrative support reaffirmed continually (every 3 years) and current at the time of verification? (CD 5-2) Type II / L1­3 (Yes/No)

* Briefly describe the administrative commitment to the trauma program (list items by numbers or bullet points):

1. Please list specific budgetary support for the trauma program such as personnel, education and equipment:
2. Is the medical staff support reaffirmed continually (every 3 years) and current at the time of verification? (CD 5-3) Type II / L1­3 (Yes/No)

* Briefly describe the medical staff commitment to the trauma program (list items by numbers or bullet points):

1. Does the trauma program involve multiple disciplines and transcend normal departmental hierarchies? (CD 5-4) Type II / L1­3 (Yes/No)

* Have an organizational chart available at the time of the site visit as attachment 5­2.

**B. Trauma Program Manager (TPM)**

1. Trauma program manager (name):

* Have the TPM job description available at the time of the site visit as attachment 5­3.

1. Education:
2. Associate in Nursing (Yes/No)
3. Bachelor in Nursing (Yes/No)
4. Masters in Nursing (Yes/No)
5. Other Degree (Yes/No)

If 'Other' degree, please describe:

1. TPM reporting status. (Check all that apply)

* TMD
* Administration
* Other (if other, please define):

1. How many years has the TPM been at that position or date of appointment to this position?
2. Total number of FTE's:  
   * List the number of support personnel including names, titles, and FTEs:
3. Does the TPM show evidence of educational preparation (a minimum of 12 hours of internal or external trauma­related continuing education per year ­ CD 5­24 / Type II / L1­2) and clinical experience in the care of injured patients? (CD 5­22) Type II / L1­3 (Yes/No)
4. Is the TPM full-time and dedicated to the trauma program? (CD 5-23) Type II / L1-2 (Yes/No)

**C. Trauma Medical Director (TMD)**

1. Does the TMD have the authority to manage all aspects of trauma care? (CD 5-9) Type II / L1­3 (Yes/No)
2. Does the trauma center’s PIPS program have a trauma multidisciplinary peer review committee chaired by the TMD? (CD 5-25) Type II / L1-3 (Yes/No)
3. Does the TMD, in collaboration with the TPM have the authority to correct deficiencies in trauma care or exclude from trauma call the trauma team members who do not meet specified criteria? (CD 5­11) Type II / L1­3 (Yes/No)  
    ***For further clarification on CD 5­11, refer to Chapter 16 in the Resources Manual.***
4. Does the TMD perform an annual assessment of the trauma panel providers in the form of Ongoing Professional Practice Evaluation (OPPE) and Focused Professional Practice Evaluation (FPPE) when indicated by findings of the PIPS process? (CD 5­11) Type II / L1­3 (Yes/No)
5. Describe the assessment process at your center:
6. Have documentation available at the time of the site visit as attachment 5­5.
7. Does the TMD have the responsibility and authority to ensure compliance with the verification requirements? (CD 5­9, CD 5­11) Type II / L1­3 (Yes/No)
8. Does the TMD direct one trauma center? (CD 5­12) Type II / L1­3 (Yes/No)

**D. Trauma Activations**

1. Are the required criteria for the highest level of activation included? (CD 5-13) Type II / L1­4 (Yes/No)  
   * List your highest level of activations:

***Examples of appropriate criteria may be found in the Resources Manual pages 38 and 39.***

1. Who has the authority to activate the trauma team? (check all that apply)

* EMS
* ED Physician
* ED Nurse
* Trauma Surgeon

1. Does the facility have a multilevel response? (Yes/No)
2. Number of levels of activation (include consults)   
   Statistics for level of response (CD 5­14, 5­15, 5­16)

|  |  |  |
| --- | --- | --- |
| Level | Number of activations | Percent of total activations |
| Highest |  |  |
| Intermediate |  |  |
| Lowest (Consult) |  |  |
| Total |  | = 100% |

1. Which trauma team members respond to each level of activation? (CD 5-13, CD 5-14)

|  |  |  |  |
| --- | --- | --- | --- |
| Activation Level | | | |
| Responder | Highest | Intermediate | Lowest |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

1. Are the other potential criteria for trauma team activation that have been determined by the trauma program to be included in the various levels of trauma activation, evaluated on an ongoing basis in the PIPS process to determine their positive predictive value in identifying patients who require the resources of the full trauma team? (CD 5-16) Type II / L1-4 (Yes/No)  
     
   ***For further clarification, refer to Chapter 16 in the Resources Manual.***
2. The emergency physician may initially evaluate the limited-tier trauma patient, but does the center have a clearly defined response expectation for the trauma surgical evaluation of those patients requiring admission? (CD 5-16) Type II / L1-3(Yes/No)  
     
   ***For further clarification, refer to Chapter 16 in the Resources Manual.***
3. Are seriously injured patients admitted to or evaluated by an identifiable surgical service staffed by credentialed providers? (CD 5-17) Type II / L1-2 (Yes/No)
4. Does the structure of the trauma program allow the trauma medical director to have oversight authority for the care of the injured patients who may be admitted to individual surgeons? (CD 5-17) Type II / L1-2 (Yes/No)  
   * If ‘No’, please explain:
5. Is there sufficient infrastructure and support to the trauma service to ensure adequate provision of care? (CD 5-19) Type I / L1-2 (Yes/No)

**VI. GENERAL SURGERY**

1. Describe the organization of your trauma service. *(Also, include number of residents, midlevel providers, etc.... that participate on the trauma service)*
2. Are all of the general surgeons (trauma surgeons on call panel) U.S. or Canadian board-certified/eligible for certification according to the current requirements? (CD 6-2) Type II / L1-3 (Yes/No)

* List all surgeons currently taking trauma call on Appendix #2.

***If 'No', please contact the VRC office immediately.*** *Surgeons/Physicians who have trained outside the United States or Canada may be eligible to participate in the trauma program through an Alternate Pathway procedure. For a current description of the Alternate Pathway, see* [*www.facs.org/quality­programs/trauma/vrc/resources*](http://www.facs.org/quality-­programs/trauma/vrc/resources)*.*

1. List those panelists who have previously or are currently utilizing the “alternate pathway” criteria, and have available at the time of the site visit as Appendix #6-1.
2. Do all of the trauma panel surgeons have privileges in general surgery? (CD 6-4) Type II / L1-3 (Yes/No)
3. Define the credentialing criteria/qualifications for serving on the trauma panel in addition to hospital credentials (list by bullet points or numbers):
4. Briefly describe how the TMD oversees all aspects of the multidisciplinary care, from the time of injury through discharge:
5. Is there 50% greater attendance documented by each of the general surgeons at the multidisciplinary trauma peer review committee? (CD 6-8, CD 16-15) Type II / L1-3 (Yes/No)

* List each general surgeon and his/her annual percentage of trauma peer review committee meeting attendance in Appendix #2.

***For an example:*** [***http://www.bioportfolio.com/resources/pmarticle/1016694/The-Use-of-a-Computer-based-Internal-Education-Program-for-Pediatric-Trauma.html***](http://www.bioportfolio.com/resources/pmarticle/1016694/The-Use-of-a-Computer-based-Internal-Education-Program-for-Pediatric-Trauma.html)

**VII. EMERGENCY MEDICINE**

1. Have a copy of the ED trauma flow sheet available at the time of the site visit as attachment 7-1.
2. Briefly describe the initial credentialing requirements for nurses who treat trauma patients in the ED:
3. Nursing staff demographics (use whole numbers, do not include percent sign)
4. Average years of experience:
5. Annual turnover %:
6. Percentage of nurses that are travelers:
7. Nursing Education (use whole numbers, do not include percent sign)
8. % ATCN:
9. % ENPC:
10. % TNCC:
11. % PALS:
12. % ACLS:
13. % TCAR:
14. % Other (enter description and percentage):
15. Extra certifications for ED nursing staff (use whole numbers, do not include percent sign)
16. % CCRN:
17. % CEN:
18. % PCEN:
19. % CNOR:
20. % CPAN:
21. % Other (enter description and percentage):
22. Briefly describe continuing trauma­related education for the nurses working in ED:
23. Does the emergency department have a designated emergency physician director supported by an appropriate number of additional physicians to ensure immediate care for injured patients? (CD 7-1) Type I / L1­3 (Yes/No)
24. Please describe hours of physician coverage and physician staffing patterns:
25. Are emergency department physicians present in the emergency department at all times? (CD 7-2) Type I / L1-2 (Yes/No)
26. Do emergency physicians ever respond to in­house emergencies? (Yes/No)

* If so, briefly describe how the ED covered in their absence:

1. Is there an emergency medicine residency training program? (Yes/No)

* If ‘Yes’, is there supervision provided by an in-house attending emergency physician 24 hours per day? (CD 7-4) Type II / L1-3 (Yes/No)

1. Are the roles of emergency physicians and trauma surgeons defined, agreed on, and approved by the director of trauma services? (CD 7-5) Type II / L1­3 (Yes/No)
2. Are all of the emergency physicians who care for injured patients U.S. or Canadian board­certified/eligible for certification according to the current requirements? (CD 7-6) Type II / L1­3 (Yes/No)

* List all emergency department physicians taking trauma call on Appendix #9.

***If 'No', please contact the VRC office immediately.*** *Surgeons/Physicians who have trained outside the United States or Canada may be eligible to participate in the trauma program through an Alternate Pathway procedure. For a current description of the Alternate Pathway, see* [*www.facs.org/quality-programs/trauma/vrc/resources*](http://www.facs.org/quality-programs/trauma/vrc/resources)*.*

1. Please list those panelists who have previously or are currently utilizing the “alternate pathway” criteria, and have available at the time of the site visit as attachment 6­1 (provided).
2. Are the emergency physicians on the call panel regularly involved in the care of injured patients? (CD 7-7) Type II / L1­3 (Yes/No)
3. Is there a representative from the emergency department participating in the prehospital PIPS program? (CD 7-8) Type II / L1­3 (Yes/No)
4. Is there a designated emergency physician liaison available to the trauma director for PIPS issues that occur in the emergency department? (CD 7-9) Type II / L1­3 (Yes/No)
5. Provide information about the emergency medical liaison to trauma program on Appendix #8.
6. Describe how the emergency physicians are actively involved with the overall trauma PIPS program: (CD 7-10) Type II / L1­3
7. Does the emergency medicine liaison on the multidisciplinary trauma peer review committee attend a minimum of 50% of the committee meetings? (CD 7-11, CD 16­15) Type II / L1­3 (Yes/No)

***For an example:*** [***http://www.bioportfolio.com/resources/pmarticle/1016694/The-Use-of-a-Computer-based-Internal-Education-Program-for-Pediatric-Trauma.html***](http://www.bioportfolio.com/resources/pmarticle/1016694/The-Use-of-a-Computer-based-Internal-Education-Program-for-Pediatric-Trauma.html)

1. Have all of the physicians who are board certified/eligible in emergency medicine successfully completed the ATLS course at least once? (CD 7-14) Type II / L1­3 (Yes/No)
2. Do the other physicians who are board certified/eligible other than emergency medicine have current ATLS status? (CD 7-15) Type II / L1­3 (Yes/No)

**VIII. NEUROSURGERY**

1. Is there a designated neurologic surgeon liaison? (CD 8-1) Type 1 / L1-2 (Yes/No)

* Provide information about the neurosurgeon liaison to the trauma program on Appendix #4.

1. Is there a mechanism in place to monitor the neurosurgeons response within 30 minutes of notification based on the institutions criteria (diagnosis)? (CD 8-2) Type I / L1-2 (Yes/No)  
   1. List the institutional criteria (diagnosis) that have been identified for the neurosurgeons 30 minute response:
2. Are qualified neurosurgeons credentialed by the hospital with general neurosurgical privileges? (CD 8-11) Type I / L1-2 (Yes/No)
3. Number of craniotomies for TBI within 24 hours of admission during the reporting year.
4. Number of severe TBI (GCS <9) on admission during the reporting year.  
     
   ***Severe TBI cohort definition, refer to*** [***www.facs.org/quality-programs/trauma/vrc/resources***](http://www.facs.org/quality-programs/trauma/vrc/resources)***.***
5. Percent of severe TBI patients who had ICP monitoring within 48 hours of admission during the reporting year. (*= Severe TBI patients (GCS <9) with ICP monitoring at 48 hours (numerator) divided by all severe TBI patients (GCS <9) at 48 hours X 100(denominator).*

* For those severe TBI patients who do not undergo ICP monitoring, is there a PI process in place to review for appropriateness? (Yes/No)

1. Does the facility have an ACGME­certified neurosurgery residency program?
2. If ‘Yes’, how many neurosurgery residents are there in the ACGME­certified training program?
3. Does the facility have any other neurosurgery training programs (e.g., osteopathic residency, fellowship programs)? (Yes/No)
4. If so, please list:
5. Is there a published backup call scheduleor system to care for neurotrauma patients when the neurosurgeon or system is overwhelmed? (CD 8-3) Type I / L1-2 (Yes/No)
6. Does the center have a predefined and thoroughly developed neurotrauma diversion plan that is implemented when the neurosurgeon on call becomes encumbered? (CD 8-4) Type II / L1-2 (Yes/No
7. If there is no back-up schedule, does the hospital provide a formal published contingency plan for times in which a neurosurgeon is encumbered upon the arrival of a neurotrauma case? (CD 8-5) Type II / L1-3
8. Please list the mechanisms used for contingency planning, e.g., published back­up schedule, resident coverage, etc.
9. Are all of the following included in the neurotrauma contingency plan?
   * A credentialing process to allow the trauma surgeon to provide initial evaluation and stabilization of the neurotrauma patient.
   * Transfer agreements with a similar or higher-level verified trauma center.
   * Direct contact with the accepting facility to arrange for expeditious transfer or ongoing monitoring support.
   * Monitoring of the efficacy of the process by the PIPS program.
10. Are the neurosurgeons dedicated to this hospital when on trauma call (ie ­ Not taking simultaneous call at another hospital)? (CD 8­6) Type II / L1­3 (Yes/No)
11. If ‘No’, is there published back-up call schedule? (Yes/No)
12. Are all of the neurosurgeons who take trauma call U.S. or Canadian board­certified/eligible for certification according to the current requirements? (CD 8-10) Type II / L1­3 (Yes/No)
13. What is the number of neurosurgeons on the call panel?
14. List all neurosurgeons taking trauma call on Appendix #5.

***If 'No', please contact the VRC office immediately.*** *Surgeons/Physicians who have trained outside the United States or Canada may be eligible to participate in the trauma program through an Alternate Pathway procedure. For a current description of the Alternate Pathway, see* [*www.facs.org/quality-programs/trauma/vrc/resources*](http://www.facs.org/quality-programs/trauma/vrc/resources)*.*

c. Please list those panelists who have previously or are currently utilizing the “alternate pathway” criteria, and have available at the time of the site visit as Appendix #6­1.

1. Describe how the neurosurgery service is actively involved with the overall trauma PIPS program: (CD 8-12) Type II / L1-2
2. Does the neurosurgery liaison attend a minimum of 50% of the multidisciplinary trauma peer review committee meetings? (CD 8-13, CD 16-15) Type II / L1-2 (Yes/No)

***For an example:*** [***http://www.bioportfolio.com/resources/pmarticle/1016694/The-Use-of-a-Computer-based-Internal-Education-Program-for-Pediatric-Trauma.html***](http://www.bioportfolio.com/resources/pmarticle/1016694/The-Use-of-a-Computer-based-Internal-Education-Program-for-Pediatric-Trauma.html)

**IX. ORTHOPAEDIC SURGERY**

1. Are there physical and occupational therapists available trauma patients? (CD 9-1) Type II / L1-2 (Yes/No)
2. Is there an Orthopaedic trauma OR available daily? (CD 9-2) Type I / L1­3 (Yes/No)

* Please describe:

1. Is there a mechanism in place to ensure operating room availability for musculoskeletal trauma cases can be scheduled without undue delay and not at inappropriate hours that might conflict with more urgent surgery or other elective procedures? (CD 9-3) Type II / L1-2 (Yes/No)

* Please describe:

1. Is there an orthopaedic surgeon who is identified as the liaison to the trauma program? (CD 9-4) Type I / L1­3 (Yes/No)

* Provide information about the Orthopaedic surgeon liaison to the trauma program on Appendix #6.

1. Are the on­call orthopaedic team members dedicated to the hospital (i.e. Do not take call simultaneously at another hospital)? (CD 9-6 / L1-2, CD 9­12 / L3) Type II (Yes/No)
2. If 'No', is there an effective back­up call system? (Yes/No)
3. If 'Yes', please describe the back­up call system:
4. Is there an orthopaedic team member promptly available in the trauma resuscitation area within 30 minutes when consulted by the surgical trauma team leader for multiple injured patients? (CD 9-7) Type II / L1-2 (Yes/No)
5. List the institutional criteria (diagnosis) that have been identified for the orthopaedic surgeon 30 minute response:
6. Does the performance improvement process ensure that care is timely and appropriate? (CD 9-8)

Type II / L1-2 (Yes/No)

1. If the on-call orthopaedic surgeon is unable to respond promptly, is there a backup consultant (PGY 4 or higher) on-call available? (CD 9-9) Type II / L1-2 (Yes/No)
2. Has the trauma program director approved the backup call system that was designed by the orthopaedic trauma liaison? (CD 9-10) Type II / L1-2 (Yes/No)
3. Does the trauma center provide all the necessary resources for modern musculoskeletal trauma care, including instruments, equipment, and personnel, along with readily available operating rooms for musculoskeletal trauma procedures? (CD 2-3) Type II / L1-2 (Yes/No)
4. Are there protocols in placed for the following orthopaedic emergencies (CD 9-14) Type II / L1-2:
5. the type and severity of pelvic and acetabular fractures that will be treated at the institutions as well as those that will be transferred out for care
6. the timing and sequence for the treatment of long bone fractures in multiply injured patients
7. the average wash out time for open fractures
   * + - 1. Are these protocols included as part of the PIPS process? (Yes/No)
         2. If ‘Yes’, please describe:
8. Average time to wash out of open tibial fractures secondary to a blunt mechanism; report as average and range:
9. Average time to first antibiotic administration for open tibial fractures secondary to a blunt mechanism:
10. The number of operations performed at this institution during the reporting year for pelvic ring and acetabular fractures secondary to a trauma mechanism, excluding isolated hip fractures:
11. Pelvic ring injuries:
12. All acetabular fracture patterns:

***Note: Do not include hip fractures or injures that result from a trip/fall.***

1. Percent of femoral shaft fractures (defined as intramedullary rod, external fixation or ORIF) stabilized within 24 hours of admission:
2. Does the orthopaedic service participate actively with the overall trauma PIPS program and the multidisciplinary trauma peer review committee? (CD 9-15) Type II / L1­3 (Yes/No)
3. Does the orthopaedic trauma liaison attend a minimum of 50% of the multidisciplinary trauma peer review meetings? (CD 9-16, CD 16­15) Type II / L1­3 (Yes/No)
4. Are all of the orthopaedic surgeons who take trauma call U.S. or Canadian board-certified/eligible for certification according to the current requirements? (CD 9-17) Type II / L1-3 (Yes/No)
5. Number of orthopaedic surgeons on the trauma call panel?
6. List all orthopaedic surgeons taking trauma call on Appendix #7.

***If 'No', please contact the VRC office immediately.*** *Surgeons/Physicians who have trained outside the United States or Canada may be eligible to participate in the trauma program through an Alternate Pathway procedure. For a current description of the Alternate Pathway, see* [*www.facs.org/quality-programs/trauma/vrc/resources*](http://www.facs.org/quality-programs/trauma/vrc/resources)*.*

1. Please list those panelists who have previously or are currently utilizing the “alternate pathway” criteria, and have available at the time of the site visit as Appendix #6­1.

***For an example:*** [***http://www.bioportfolio.com/resources/pmarticle/1016694/The-Use-of-a-Computer-based-Internal-Education-Program-for-Pediatric-Trauma.html***](http://www.bioportfolio.com/resources/pmarticle/1016694/The-Use-of-a-Computer-based-Internal-Education-Program-for-Pediatric-Trauma.html)

**X. PEDIATRIC TRAUMA SURGERY**

***If seeking a visit as a combined Level I or Level II adult with a Level II pediatric, only one PRQ is provided. The tables in Chapter II should include the adult and pediatric statistical data. ONLY use pediatric statistical data in Chapter X and complete the entire section.***

***For all other centers that admit adult and pediatric patients, the tables in Chapter II should include the adult and pediatric statistical data combined. Then in Chapter X use pediatric statistical data ONLY to answer the following: Section A question 1; Section B-Splenic Injury Table, and all of section C.***

***For all other centers that admit ONLY pediatric patients, the data tables are split between Chapter II and Chapter X, and are not duplicated. In regard to the PICU, questions are split between the ICU section and PICU section, again questions are not duplicated.***

**A. Pediatric Nursing**

1. Define the age of the pediatric patient at your institution*:*
   1. How many of these patients were admitted younger than 15 years of age?

**B. Splenic Injuries**

1. Pediatric patients admitted with splenic injuries during the reporting year.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Grade of Spleen Injury | # of Splenic Injuries | # Undergoing (IR) Embolization | # of Splenorrhaphy | # of Splenectomy |
| Grade I |  |  |  |  |
| Grade II |  |  |  |  |
| Grade III |  |  |  |  |
| Grade IV |  |  |  |  |
| Grade V |  |  |  |  |
| TOTALS |  |  |  |  |

**C. Pediatric Trauma Admissions**

1. Pediatric Trauma Admissions (CD 2-25, CD 10-1, CD 10-2) Type I / PTC1

|  |  |
| --- | --- |
| Service | Number of Admissions |
| Pediatric Trauma Surgery |  |
| Orthopaedic |  |
| Neurosurgical |  |
| Other Surgical |  |
| Burn |  |
| Non-Surgical |  |
| Total Trauma Admissions |  |

1. Based on the number of Non-surgical admits (NSA) from Table 7, please complete the following:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Non-surgical admissions (NSA) | ISS | | | |
|  | 0-9 | 10-15 | 16-24 | >=25 |
| Number of patients admitted to a non-surgical service (from Chapter 10, Table 5) |  |  |  |  |
| Percent of total NSA |  |  |  |  |
| Total NSA w/ trauma consult |  |  |  |  |
| Total NSA w/any surgical consult (including trauma) |  |  |  |  |
| Total NSA secondary to single level falls |  |  |  |  |
| Total mortality (for each ISS category) |  |  |  |  |

1. Does the trauma program admit more than 10% of injured patients to non-surgical services? (CD 5-18) Type II / L1-3 (Yes/No)  
     
   ***For further clarification, refer to Chapter 16 in the*** ***Resources Manual.***
2. Were all patients in table 8 reviewed by the TPM and TMD for appropriateness of admission and other opportunities for improvement? (Yes/No)
3. Have documentation available at the time of the site visit as attachment 10-1.
4. Injury and Severity and Mortality (CD 2-25, CD 10-1, CD 10-2) Type I / PTC1

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ISS | (A)Total Number of Pediatric Admissions | (B)Total Number of Death from Pediatric Admissions by ISS | Percent Mortality (B over A) | Number Admitted to Pediatric Trauma Service |
| 0-9 |  |  |  |  |
| 10-15 |  |  |  |  |
| 16-24 |  |  |  |  |
| >or=25 |  |  |  |  |
| Total |  |  |  |  |

**D. Pediatric TPM**

1. Does the pediatric trauma center have a dedicated TPM? (CD 10-3) Type I / PTC 1-2 Yes No

a. Pediatric trauma program manager (name):

b. Have pediatric TPM job description available at the time of the site visit as attachment 10-2.

1. To whom does the pediatric TPM report?
2. Is the pediatric TPM a full-time position dedicated to the pediatric trauma service? (CD 10-5) Type II / PTC1

Yes No

**E. Pediatric Trauma Service**

1. Does the pediatric trauma center have a pediatric trauma registrar? (CD 10–4) Type II / PTC 1-2 (Yes/No)
2. For all pediatric trauma centers, are the following programs available? (CD 10–7) Type II / PTC1-2 (Check all available programs)

* Pediatric rehabilitation
* Child life and family support programs
* Pediatric social work
* Child protective services
* Pediatric injury prevention
* Community outreach
* Education of health professionals and the general public in the care of pediatric trauma patients

1. Does the pediatric trauma center have a mechanism in place to assess children for maltreatment? (CD 10-8) Type II / PTC 1-2 (Yes/No)
2. Describe the mechanism at your center:
3. Is there a Child Maltreatment physician on staff? (Yes/No)
4. Number of surgeons/physicians with additional pediatric boards/training (Fellowship):
5. Pediatric Surgery (CD 10-12, CD 10-21) Type I / PTC1-2
6. Number of surgeons/physicians with demonstrated interest and skills in pediatric trauma care:
7. Orthopaedic Surgery (CD 10-15, CD 10-22) Type II / PTC1-2
8. Neurosurgery (CD 10-16, CD 10-23) Type II / PTC1-2
9. Emergency Medicine (CD 10-20) Type II / PTC1-2
10. Critical care medicine (CD 10-19) Type II / PTC1-2
11. If the number of pediatric surgeons on staff is too few to sustain the pediatric trauma panel, does the hospital have a credentialing process that is approved by the pediatric TMD for the adult trauma panel to serve on a pediatric trauma panel? (CD 10-26) Type I / PTC1-2 (Yes/No)

* Please list the additional credentialing requirements required for a surgeon that is not board eligible or eligible for certification in pediatric surgery to serve on the pediatric trauma call panel:

**F. Pediatric TMD**

1. Pediatric trauma medical director (name):
2. When the pediatric TMD is not a board certified/eligible pediatric surgeon, does the pediatric TMD have: (PTC1-2)
3. Credentialed by the hospital to provide pediatric trauma care
4. A member of the adult trauma panel
5. Participate in trauma call
6. Current in PALS certification –or – the Society of Critical Care Medicine Fundamentals of Pediatric Critical Care
7. Accrue an average of 12 hours annually or hours in 3 years of verifiable external trauma-related CME - of which at least 12 hours (in 3 years) must be related to clinical pediatric trauma care,
8. A formal relationship with a pediatric surgeon who serves as a TMD in a verified program for help with PI and protocol development
9. Is the pediatric TMD a member and an active participant in national or regional trauma organizations?(CD 5-8) Type II / L1-2

Please List.

1. Is the pediatric TMD board-certified/eligible according to current requirements for general surgery or an ACS Fellow with a special interest in pediatric trauma care? (CD 10-25) Type I / PTC2 (Yes/No)  
   1. Provide information about the pediatric TMD on Appendix #1 or 14, but do not complete both.
   2. Have the pediatric TMD job description available at the time of the site visit labeled as attachment 10-3.
2. Does the hospital provide pediatric education available for other specialists? (CD 10-29) Type II / PTC1-2 (Yes/No)
3. Is there an organized pediatric trauma service led by a pediatric TMD present at the center? (CD 10-30) Type I / PTC1-2 (Yes/No)

* If ‘Yes’, briefly describe:

**G. Pediatric Intensive Unit (PICU)**

1. Does the pediatric trauma service maintain oversight of the patient’s management while the patient is in the PICU? (CD 10-31) Type I / PTC1-2 (Yes/No)
2. Which physician maintains primary responsibility for the care of the patient in the PICU? (CD 10-32) Type II / PTC1-2

* Surgeon
* Pediatric ICU intensivist
* Other (if other, please explain):

1. Medical director of the PICU (name):
2. Surgical director of the PICU (name):
3. Does the Surgical Director of the PICU participate actively in the development and protocols for the surgical patients? (CD 10-33) Type I / PTC1-2 (Yes/No)
4. Are the pediatric surgeons or trauma surgeons with pediatric privileges included in all aspects of the care of injured children admitted to the PICU? (CD 10-34) Type II / PTC1-2 (Yes/No)
5. Does the pediatric TMD chair (CD 10-36) attend a minimum of 50% of the multidisciplinary trauma peer review committee meetings? (CD 10-37, CD 16-15) Type II / PTC1-2 (Yes/No)
6. Is there 50% or greater attendance documented by each of the pediatric and general surgeons serving on the pediatric trauma panel at the multidisciplinary trauma peer review committee? (CD 10–37, CD10-38) Type II / PTC1-2 (Yes/No)

* List each pediatric/general surgeon and his/her annual percentage of trauma peer review committee meeting attendance in Appendix #11a.

***For an example:*** [***http://www.bioportfolio.com/resources/pmarticle/1016694/The-Use-of-a-Computer-based-Internal-Education-Program-for-Pediatric-Trauma.html***](http://www.bioportfolio.com/resources/pmarticle/1016694/The-Use-of-a-Computer-based-Internal-Education-Program-for-Pediatric-Trauma.html)

**XI. COLLABORATIVE CLINICAL SERVICES**

**A. Anesthesiology**

1. Are anesthesiology services available within 30 minutes for emergency operations? (CD 11–1) Type I / L1­3 (Yes/No)
2. Are anesthesiology services promptly available within 30 minutes for airway problems? (CD 11-2) Type I / L1­3 (Yes/No)
3. Is there an anesthesiologist/CRNA\* who is highly experienced and committed to the care of injured patients and who serves as the designated liaison to the trauma program? (CD 11-3) Type I / L1-2 (Yes/No)

\*Only for Level III, where CRNA\* are licensed to practice independently may function as the anesthesia liaison, refer to Clarification Document.

Name:

Provide information about the anesthesiologist liaison to the trauma program on Appendix #10.

1. Does the facility have anesthesia services available in-house 24 hours a day? (CD 11-4) Type I / L1-2 (Yes/No)

* If yes, which of the following:
  + MD Anesthesiologist
  + CRNA or Certified Anesthesiologist’s Assistants (C-AA)
  + Resident

1. Who fulfills the in-hospital requirements for anesthesia services?
2. Number of anesthesiologists on staff?
3. How many anesthesiologists are on backup call during off­hours?

* Describe the anesthesiology on­call schedule:

1. Does the center utilize anesthesiology senior residents, CRNAs or certified Anesthesiologists Assistants to fulfill availability requirements? (Yes/No)

* If ‘Yes’, is the on call attending anesthesiologist available within 30 minutes at all times, and present for all operations? (CD 11-5) Type I / L1-2 (Yes / No)
* Describe how this is monitored at your institution:

1. Is the availability of the anesthesia services and the absence of delays in airway control or operations documented by the hospital PIPS process? (CD 11­6) Type II / L1­3 (Yes/No)
2. Have all of the anesthesiologists taking call successfully completed an anesthesiology residency? (CD 11-10) Type I / L1-2 (Yes/No)
3. Is the anesthesiologist liaison who takes trauma call a current board-certified/eligible for certification according to current requirements in anesthesiology? (CD 11-11) Type II / L1-2 (Yes/No)

**B. Operating Room**

1. Is the operating room adequately staffed and available within 15 minutes? (CD 11-14) Type I / L1-2 (Yes/No)
2. Number of operating rooms:
3. Number of times when OR not available within 15 minutes for an emergent trauma case:
4. Briefly describe the location of the operating suite related to the ED and ICU.
5. If the first operating room is occupied, is there a mechanism for providing additional staff for a second operating and is it monitored through the PIPS process? (CD 11-15, CD 11-16) Type II / L1-2 (Yes/No)
6. What is the number of teams on call and their expected response time:
7. Describe how the backup team is called if the primary team is busy and how is this documented in the PIPS process:
8. Number of times the back-up team was called in:
9. Describe your mechanism for OR availability for urgent trauma cases:
10. Describe your mechanism for OR availability for non-urgent trauma cases during daylight hours:
11. Is there a mechanism for documenting trauma surgeon presence in the operating room for all trauma operations? (CD 6-7) Type II / L1­3 (Yes/No)
12. If 'Yes', please describe:
13. Does the operating room have all essential equipment? (CD 11-19) Type I / L1-3 (Yes/No)
14. Does the trauma center have the necessary equipment to perform craniotomy? (CD 11-20) Type I / L1­3 (Yes/No)
15. If there is not a CPB immediately available, is there a contingency plan? (CD 11-22) Type II / L1-2 (Yes/No)
16. If there is a transfer policy, does the trauma center review the patients transferred in their performance improvement process? (Yes/No)
17. Does the center have cardiothoracic surgery capabilities available 24 hours per day and have cardiopulmonary bypass equipment (CPB)? (CD 11–21) Type II / L1 (Yes/No)
18. If there is not a CPB immediately available, is there a contingency plan? (CD 11-22) Type II / L1-2 (Yes/No)
19. If there is a transfer policy, does the trauma center review the patients transferred in their performance improvement process? (Yes/No)
20. Does the trauma center have an operating microscope available 24 hours per day? (CD 11-23) Type II / L1 (Yes/No)

**C. Post-Anesthesia Care Unit (PACU)**

1. Number of beds:
2. Is the PACU ever used as an overflow for the ICU? (Yes/No)
3. Does the PACU have qualified nurses available 24 hours per day as needed during the patient's post­anesthesia recovery phase? (CD 11­24) Type I / L1­3 (Yes/No)
4. Is the PACU covered by a call team from home?
5. If ‘Yes’, is there documentation by the PIPS program that PACU nurses are available and delays are not occurring? (CD 11-25) Type II / L1­3 (Yes/No)
6. If 'Yes', please describe:
7. Briefly describe credentialing requirements for nurses who care for trauma patients in PACU:
8. Nursing Education (use whole numbers, do not include percent sign)
9. % ENPC:
10. % TNCC:
11. % PALS:
12. % ACLS:
13. % TCAR:
14. % Other (enter description and percentage):
15. Extra certifications for PACU staff (use whole numbers, do not include percent sign)
16. % CCRN:
17. % CEN:
18. % PCEN:
19. % CNOR:
20. % CPAN:
21. % Other (enter description and percentage):
22. Does the PACU have the necessary equipment to monitor and resuscitate patients? (CD 11­26) Type I / L1­3 (Yes/No)

**D. Radiology**

1. Does the trauma center have policies designed to ensure that trauma patients who may require resuscitation and monitoring are accompanied by appropriately trained providers during transportation to and while in the radiology department? (CD 11-28) Type II / L1­3 (Yes/No)

* Please describe:

1. Who provides FAST for trauma patients? (Check all that apply)
2. Radiology
3. Surgery
4. ED Physician
5. None
6. Describe your institution’s policy for obtaining FAST exams for injured patients:
7. Describe your institution’s QI policy for FAST exams:
8. Is there adult and pediatric resuscitation and monitoring equipment available in the radiology suite? (Yes/No)
9. Are conventional radiography (CD 11­29 / L1­4) and computed tomography (CD 11­30 / L1­3) available 24 hours per day? Type I (Yes/No)
10. Is there an in-house radiology technologist and CT technologist 24 hours per day? (CD 11-31) Type I / L1-2 (Yes/No)
11. Are radiologists available within 30 minutes in person or by teleradiology, when requested for the interpretation of radiographs? (CD 11­32) Type I / L1­3 (Yes/No)
12. Are radiologists in­house 24/7? (Yes/No)
13. If 'No', who reads x­rays after hours?
14. How is diagnostic information from radiologic studies communicated to the trauma team?
15. If an error is identified on initial radiologic interpretation, what is the policy for notifying the physician?
16. Are radiologists available within 30 minutes to perform complex imaging studies, or interventional procedures? (CD 11-33) Type II / L1-2 (Yes/No)
17. Is diagnostic information communicated in a written electronic form and in a timely manner? (CD 11­34) Type II / L1­3 (Yes/No)
18. Is critical information deemed to immediately affect patient care verbally communicated to the trauma team in a timely manner? (CD 11-35) Type II / L1­3 (Yes/No)
19. Do final reports accurately reflect the chronology and content of communications, including changes between preliminary and final interpretations? (CD 11-36) Type II / L1­3 (Yes/No)
20. Are changes in interpretation between preliminary and final reports, as well as missed injuries monitored through the PIPS program? (CD 11-37) Type II / L1­3 (Yes/No)
21. Describe your institution’s process for tracking changes in radiology interpretation and missed injuries.
22. Describe how these are monitored through PIPS:
23. Is there a radiologist who is appointed as liaison to the trauma program? (CD 11-38) Type II / L1-2 (Yes/No)

* Name:
* Provide information about the radiologist liaison to the trauma program on Appendix #12.

1. Does the Radiology department participate in the trauma PIPS program by at least being involved in protocol development and trend analysis that relate to diagnostic imaging? (CD 11-41) Type II / L1-2 (Yes/No)

* Please describe:

1. Does the facility have a mechanism in place to view radiographic imaging from referring hospitals within their catchment area? (CD 11-42) Type II / L1-2 (Yes/No)

* Describe your institution’s mechanisms to view these images:

1. Is the radiology liaison who takes trauma call a current board-certified/eligible for certification according to current requirements in radiology? (CD 11-43) Type II / L1-2 (Yes/No)
2. Are interventional radiologic procedures and sonography available 24 hours per day? (CD 11-44) Type I / L1-2 (Yes/No)

* Describe the institutional guidelines for interventional radiology response times and how they are tracked:

1. Is MRI capability available 24 hours per day? (CD 11-45) Type II / L1-2 (Yes/No)
2. Is the MRI technologist arrival within 1 hour of being called documented and reviewed through the PIPS process? (CD 11-46) Type II / L1-2 (Yes/No)

**E. Intensive Care Unit (ICU)**

1. ICU Beds.
2. Total ICU beds (Includes medical, coronary, surgical, pediatric, etc):
3. Pediatric ICU beds:
4. Adult ICU beds:
5. Do you have a step­down or intermediate care unit? (Yes/No)
6. Describe how quality of care issues are resolved in the ICU:
7. Does your institution have palliative care available? (Yes/No)
8. If 'Yes', describe how this palliative care team is incorporated into end of life issues:
9. Total number of Trauma ICU deaths:
10. Of these deaths, # of withdrawal of care:
11. Of these deaths, # transferred to hospice care:

1. Are there appropriately trained physicians available in-house within 15 minutes 24 hours per day for the ICU? (CD 11-51, CD 11-55) Type I / L1-2 (Yes/No)
2. Please describe how physician coverage of critically ill trauma patients is promptly available 24 hours per day:
3. During the day:
4. During after hours:
5. Who responds to acute issues in the ICU after hours?
6. Does the trauma center have a surgical director or co­director for the ICU who is responsible for setting policies and administration related to trauma ICU patients? (CD 11­53) Type II / L2­3 (Yes/No)
7. Is the ICU director or co­director a surgeon who is board certified/eligible for certification by the current standard requirements? (CD 11-54) Type II / L2­3 (Yes/No)
8. Does the trauma surgeon retain responsibility for the patient and coordinate all therapeutic decisions in the ICU? (CD 11­58) Type I / L1­3 (Yes/No)
9. Is the trauma surgeon kept informed of and concurs with major therapeutic and management decisions made by the ICU team? (CD 11­59) Type I / L1­3 (Yes/No)
10. Does the PIPS program document the timeliness and appropriate ICU care and coverage is being provided? (CD 11-60) Type II / L1­4 (Yes/No)
11. Is there designated ICU liaison to the trauma service? (CD 11-61) Type II / L1­3 (Yes/No)

* Name:

1. Are qualified critical care nurses available 24 hours per day to provide care during the ICU phase? (CD 11­65) Type I / L1­3 (Yes/No)
2. Briefly describe the initial credentialing requirements for nurses who care for trauma patients in the ICU:
3. Nursing staff demographics (use whole numbers, do not include percent sign)
4. Average number of years’ experience:
5. Annual turnover %:
6. Percentage of nurses that are travelers:
7. Nursing Education (use whole numbers, do not include percent sign)
8. % ATCN:
9. % ENPC:
10. % TNCC:
11. % PALS:
12. % ACLS:
13. % TCAR:
14. % Other (enter description and percentage):
15. Extra certifications for ICU nursing staff (use whole numbers, do not include percent sign)
16. % CCRN:
17. % CEN:
18. % PCEN:
19. % CNOR:
20. % CPAN:
21. % Other (enter description and percentage):
22. Briefly describe continuing trauma­related education for the nurses working in ICU:
23. The patient/nurse ratio does not exceed 2:1 for critically ill patients in the ICU. (CD 11­66) Type II / L1­3 (Yes/No)

* If 'No', please describe:

1. Does the ICU have the necessary equipment to monitor and resuscitate patients? (CD 11­67) Type I / L1­3 (Yes/No)
2. Is intracranial pressure monitoring equipment available? (CD 11-68) Type I / L1­3 (Yes/No)

**Only Level III trauma centers that do not offer neurosurgery services are not required to have craniotomy equipment.**

**F. Primary Care Physicians**

**G. Other Surgical Specialists**

1. Are the following surgical specialists available? (CD 11-70, CD 11-71) Type I / L1-2 (Yes/No)  
     
   Check all available surgical specialists:

* Orthopaedic surgery
* Neurosurgery
* Cardiac surgery (not required for L2)
* Thoracic surgery
* Vascular surgery
* Hand surgery
* Microvascular surgery
* Plastic surgery
* Obstetric and Gynecologic surgery
* Ophthalmology
* Otolaryngology
* Urology

1. *For all patients being transferred for specialty care, such as burn care or replantation surgery, cardiopulmonary bypass capability, complex ophthalmologic surgery, or high­complexity pelvic fractures, agreements with a similar or higher­qualified verified trauma center should be in place.*
2. For complex cases being transferred out, does the contingency plan (CD 8-5, Type II / L1­3) include the following:
   1. A credentialing process to allow the trauma surgeon to provide initial evaluation and stabilization of the patient.
   2. Transfer agreements with similar or higher-verified trauma centers.
   3. Direct contact with the accepting facility to arrange for expeditious transfer or ongoing monitoring support.
   4. Monitoring of the efficacy of the process by the PIPS programs.
3. Which patients are being transferred for specialty care from your institution?

**H. Medical Consultants**

1. The medical specialists on staff include: (Check all that apply) (CD 11-73) Type II / L1-2
2. Cardiology
3. Internal medicine (required at L3 (CD 11-74) Type II)
4. Gastroenterology
5. Infectious disease,
6. Pulmonary medicine
7. Nephrology
8. Respective support teams (for example: respiratory therapy / dialysis team / nutrition support)

**I. Support Services**

1. Is a respiratory therapist available in the hospital call 24 hours per day? (CD 11-75) Type I / L1-2 (Yes/No)
2. Is acute hemodialysis available? (CD 11-77) Type II / L1-2 (Yes/No)

* Please describe what modes of dialysis are available:

1. Are nutritional support services available? (CD 11-79) Type II / L1-2 (Yes/No)

**J. Clinical Laboratory and Blood Bank**

1. Are laboratory services available 24 hours per day for the standard analysis of blood, urine, and other body fluids, including microsampling when appropriate? (CD 11­80) Type I / L1­4 (Yes/No)
2. Is the blood bank capable of blood typing and cross matching? (CD 11­81) Type I / L1­4 (Yes/No)
3. What is the average turnaround time for type­specific blood (minutes)?
4. What is the average turnaround time for full cross­matched blood (minutes)?
5. Does the blood bank have an adequate in-house supply of red blood cells, fresh frozen plasma, platelets, cryoprecipitate, and appropriate coagulation factors to meet the needs of injured patients? (CD 11-82) Type I / L1-2 (Yes/No)
6. How many units of packed red blood cells on average are available in the blood bank?
7. How many units of plasma on average are available in the blood bank?
8. How many units of platelets on average are available in the blood bank?
9. Does the facility have uncross-matched blood immediately available? (Yes/No)
10. Does you facility have thawed plasma immediately available? (Yes/No)
11. For your highest level of activations, how is blood made available in the ED?
12. Does the facility have a massive transfusion protocol developed collaboratively between the trauma service and the blood bank? (CD 11­84) Type I / L1­4 (Yes/No)
13. Describe your MTP:
14. Number of times activated in the last year:
15. Describe your PIPS process, if any, for MTP activation:
16. Do you have an anticoagulation reversal protocol? (Yes/No)
17. Please describe:
18. Which products do you have available for rapid anticoagulation reversal other than Vitamin K and fresh frozen plasma?
19. Do they require approval for emergent use?
20. Is there 24 hour per day availability for coagulation studies, blood gas analysis, and microbiology studies? (CD 11­85) Type I / L1­3 (Yes/No)

**K. Advanced Practitioners**

1. Does the trauma or ED utilize APs in the initial evaluation of trauma patients during the activation phase? (CD 11-86) Type II / L1­4 (Yes/No)
2. If yes, are the APs current in ATLS? (Yes/No)
3. Have information about the advanced practitioners available at the time of the site visit as attachment 11­1.
4. Which advanced practitioners participate in the initial evaluation of trauma patients? (Check all that apply)
5. Trauma
6. Emergency medicine
7. Orthopaedics
8. Neurosurgery
9. Other (if other, please describe):
10. Does the trauma program demonstrate appropriate orientation, credentialing processes, and skill maintenance for advanced practitioners, as witnessed by an annual review by the TMD? (CD 11–87) Type II / L1­4 (Yes/No)

**XII. REHABILITATION SERVICES**

1. Who is the medical director of the rehabilitation program?  
    Name
2. Is this physician board certified? (Yes/No)
3. If 'Yes', what specialty?
4. Describe the composition of your in­house rehabilitation team:
5. Describe the role and relationship of the rehabilitation services to the trauma service (include where and when rehabilitation begins):
6. Is there a pediatric rehabilitation service? (Yes/No)
7. If 'Yes', please describe:
8. If ‘No', please describe how rehabilitation service are adapted for pediatric patients:
9. Which of the following services does the hospital provide? (Check all that apply)

* Physical therapy (CD 12-3) Type I / L1-3
* Social services (CD 12-4) Type II / L1-3
* Occupational therapy (CD 12-5) Type II / L1-2
* Speech therapy (CD 12-6) Type II / L1-2

1. Are rehabilitation consultation services, occupational therapy, speech therapy, physical therapy, and social services available during the acute phase of care, including the ICU? (CD 12-2) Type II / L1-2 (Yes/No)
2. Is there a dedicated social worker for trauma service? (Yes/No)

* If 'No', what is the commitment from Social Services to the trauma patient?

1. Describe the support services available for crisis intervention and individual/family counseling:
2. Does the trauma center have a rehabilitation facility within its physical plant? (CD 12-1) Type II / L1-2 (Yes/No)
3. If ‘inpatient rehabilitation unit’, is it CARF approved? (Yes/No)
4. Number of inpatient beds:
5. If ‘freestanding rehabilitation hospital’, does the hospital have transfer agreements? (CD 12-1) Type II / L1-2 (Yes/No)
6. Is there a screening program in place for PTSD? (Yes/No)  
   ***Refer to clarification document at:*** [***http://www.facs.org/quality-programs/trauma/vrc/resources***](http://www.facs.org/quality-programs/trauma/vrc/resources)

**XIV. BURN PATIENTS**

1. Number of burn patients admitted during the reporting year:
2. Is there a separate burn team? (Yes/No)
3. Is the institution a verified burn center? (Yes/No)
4. Number of burn patients transferred for acute care during reporting year.

* Transferred In:
* Transferred Out:

1. Does the trauma center that refer burn patients to a designated burn center have in place a written transfer agreement with the referral burn center? (CD 14-1) Type II / L1­4 (Yes/No)

**XV. TRAUMA REGISTRY**

1. What registry program does the hospital use?
2. Are trauma registry data collected and analyzed? (CD 15­1) Type II / L1­4 (Yes/No)  
     
   ***For further clarification, refer to Chapter 16 in the Resources Manual.***
3. Is this data submitted to the National Trauma Data Bank® (NTDB®) every year in a timely fashion so that they can be aggregated and analyzed at the national level? (CD 15-2, CD 10­35) Type II / L1­3 / PTC1­2 (Yes/No)  
     
   ***Please refer to the NTDS at*** [***http://www.ntdsdictionary.org/dataElements/datasetDictionary.html***](http://www.ntdsdictionary.org/dataElements/datasetDictionary.html)
4. Does the trauma registry support the PIPS process? (CD 15-3) Type II / L1­4 (Yes/No)

* Describe how the registry is used in the PIPS process to identify and track opportunities for improvement:

1. Does the center participate in a risk-adjusted benchmarking program? (CD 15­5) Type II / L1­3 (Yes/No)
2. What risk-adjusted benchmarking program does the hospital participate in? (select one) TQIP or Other
3. If TQIP, please share your TQIP report with the onsite team or have it available at the time of the visit.
4. For 'Other', please describe and provide contact information (i.e. website):

*(NTDB is not a risk-adjusted benchmarking system / Staff will initiate contact to obtain program information.)*

1. For a current description of approved risk-adjusted benchmarking system, see www.facs.org/quality-programs/trauma/vrc/resources.
2. Provide an example of how the risk-adjusted benchmarking data is shared within the PI committees or with trauma program stakeholders.
3. Are at least 80% of the trauma cases entered into the trauma registry within 60 days of discharge? (CD 15­6) Type II / L1­4 (Yes/No)  
     
   ***For further clarification, refer to Chapter 16 in the Resources Manual.***
4. Has the registrar attended or previously attended two courses within 12 months of being hired? (CD 15-7) Type II / L1­3 (Yes/No)

a. If ‘Yes’, please check all that apply.

* The American Trauma Society’s Trauma Registrar Course or
* (Other) equivalent provided by a regional/state trauma program
* the Association of the Advancement of Automotive Medicine’s Injury Scaling Course

b. If ‘Other’, please briefly describe

1. Does the trauma program ensure that trauma registry confidentiality measures are in place? (CD 15­8) Type II / L1­4 (Yes/No)

* If 'Yes', please explain:

1. Is there one full­time equivalent employee dedicated to the registry available to process the data capturing of the NTDS data set for each 500–750 admitted trauma patients annually? (CD 15-9) Type II / L1­3 (Yes/No) (Centers admitting less than 500 trauma admissions, select ‘Yes’)
2. Please describe the FTE staffing model for the registry:
3. Are there strategies for monitoring data validity for the trauma registry? (CD 15­10) Type II / L1­4 (Yes/No)

* If 'Yes', please explain:

1. Describe the registry data validation process used by the center. For example provide the percentage of charts abstracted by another registrar, audits performed by benchmark sources, state audits, etc.:

**XVI. PERFORMANCE IMPROVEMENT AND PATIENT SAFETY (PIPS)   
  
A. Performance Improvement PI Program**

1. Are the TMD and TPM knowledgeable and involved in trauma care collaboratively with guidance from the trauma peer review committee to identify events, develop corrective action plans, and ensure methods of monitoring, reevaluation, and benchmarking? (CD 2­17) Type II / L1­4 (Yes/No)
2. Describe how your PI plan incorporates or assigns levels of review (primary, secondary, tertiary) for events/issues identified through the PI process:
3. Does the multidisciplinary trauma peer review committee meet regularly, with required attendance of medical staff active in trauma resuscitation, to review systemic and care provider issues, as well as propose improvements to the care of the injured? (CD 2-18) Type II / L1­4 (Yes/No)

***For further clarification, refer to Chapter 16 in the Resources Manual.***

1. Is there a rigorous multidisciplinary performance improvement to evaluate overtriage and undertriage rates to attain the optimal goal of less than 5 percent undertriage? (CD 3-3) Type II / L1­3 (Yes/No)
2. Are the rates of undertriage and overtriage monitored and reviewed quarterly? (CD 16-7) Type II/L1-3
3. Please describe how the undertriage and overtriage rates are monitored and reviewed

***For further clarification, refer to Chapter 16 in the Resources*** ***Manual.***

1. Are nursing issues reviewed in the trauma PI Process? (Yes/No)

* If 'No', briefly describe how nursing units ensure standards and protocols are followed:

1. Autopsies have been performed on what percentage of the facility's trauma deaths?

* How are the autopsy findings reported to the trauma program?

1. Does the PIPS plan include a comprehensive written plan outlining the configuration and identifying both adequate personnel to implement that plan and an operational data management system? (CD 16-1) Type II/L1-3 (Yes/ No)
2. Describe how the trauma center's PIPS program includes a comprehensive written plan outlining the configuration and identifying both adequate personnel to implement that plan and an operational data management system:
3. Does the PIPS program have audit filters to review and improve pediatric and adult patient care? (CD 2-19) Type II / L1-4 (Yes/No)  
     
   ***For further clarification, refer to Chapter 16 in the Resources*** ***Manual.***
4. List at least 3 adult specific PI filters:
5. List at least 3 pediatric specific PI filters:
6. Are problem resolution, outcome improvements, and assurance of safety (''loop closure'') readily identifiable through methods of monitoring, reevaluation, benchmarking, and documentation? (CD 16-2) Type II/L1-3 (Yes/No)
7. Please describe how the program identifies problem resolution, outcome improvements, and loop closure:
8. Who is responsible for loop closure of both system and peer review issues?
9. List 2 examples of loop closure involving peer review issues during the reporting year:
10. List 2 examples of loop closure involving system issues during the reporting year:
11. Does the trauma PIPS program demonstrate integration with the hospital quality and patient safety effort and have a clearly defined reporting structure and a method for provision of feedback? (CD 16-3) Type II / L1-3 (Yes/No)
12. Please describe how the trauma PIPS program integrates with the hospital quality and patient safety efforts:
13. In an effort to reduce unnecessary variation in care provided, does the trauma program use clinical practice guidelines, protocols, and algorithms derived from evidenced­based validated resources? (CD 16-4) Type II / L1­3 (Yes/No)
14. Are all the process and outcome measures documented within the PIPS program plan and reviewed and updated annually? (CD 16-5) Type II / L1­4 (Yes/No)

**B. Mortality Review**

1. Are all trauma­related mortalities systematically reviewed with opportunities for improvement? (CD 16-6,) Type II / L1­3 (Yes/No)

* Briefly describe the process:

1. How many trauma deaths were there during the reporting year?
2. DOA:
3. Deaths in ED (DIED):
4. In­hospital (include OR):
5. List the number of deaths categorized as follow:
6. Mortality without Opportunity for Improvement:
7. Mortality with Opportunity for Improvement:
8. Unanticipated mortality with Opportunity for Improvement:

**C. Event Identification Review**

1. Are there sufficient mechanisms available to identify events for review by the trauma PIPS program? (CD 16-10) Type II / L1­4 (Yes/No)
2. Once an event is identified, does the trauma PIPS program verify and validate that event? (CD 16-11) Type II/L1-4
3. Please describe how the events are verified and validated through the PIPS process:
4. Is there a Multidisciplinary Trauma Systems/Operations Committee? (CD 16-12). Type II / L1­3 (Yes/No)
5. Is there documentation (minutes) reflecting the review of operational events and, when appropriate, the analysis and proposed corrective actions? (CD 16-13) Type II / L1­3 (Yes/No)
6. Do identified problem trends undergo multidisciplinary trauma peer review? (CD 16-14) Type II / L1­3 (Yes/No)

* If 'Yes', please describe:

1. Does the TMD ensure and document dissemination of information and findings from the multidisciplinary trauma peer review meetings to the non­liaisons physicians/surgeons on the trauma call panel? (CD 16-16,). Type II / L1­3

* If 'Yes', please describe:

1. Does the PIPS program systematically review mortalities, significant complications, and process variances associated with unanticipated outcomes and determine opportunities for improvement? (CD 16-17) Type II / L1-3 (Yes/No)
2. When an opportunity for improvement is identified, are appropriate corrective actions to mitigate or prevent similar future adverse events developed, implemented, and clearly documented by the trauma PIPS program? (CD 16-18) Type II / L1-3 (Yes/No)
3. Does the performance improvement program demonstrate through documentation that identified opportunities for improvement lead to specific interventions that result in an alteration in conditions such that similar adverse events are less likely to occur? (CD 16-19) Type II / L1-3 (Yes/No)
4. Provide a description of the two committees with trauma PI involvement, including Multidisciplinary Peer Review (Appendix #11a) and Multidisciplinary System Review in Appendix #11b.

**D. Evidenced-Based Guideline**

1. Does the facility have a manual for evidenced­based trauma guidelines and protocols? (Yes/No)

* If 'Yes', have a copy available at the time of the site visit as attachment 3­2.
* How many and how are they developed?

1. Has the trauma program instituted any 'evidenced­based' trauma guidelines and protocols since the last review?
2. If 'Yes', briefly describe:
3. Briefly describe how compliance with the guidelines and protocols are monitored:

**XVII. EDUCATION ACTIVITIES / OUTREACH PROGRAMS**

1. Is the trauma center engaged in public and professional education? (CD 17­1) Type II / L1­4 (Yes/No)
2. Does the trauma center provide some means of referral and access to trauma center resources? (CD 17-2) Type II / L1-2 (Yes/No)
3. Is this hospital a teaching facility? (Yes/No)
4. If 'Yes', are the requirements of the Residency Review Committee met? (CD 5-20) Type II / L1-2
5. Please describe the resident complement on the trauma service. L2
6. Does the facility have a trauma or surgical critical care fellowship? (Yes/No)

* If ‘Yes’, briefly describe:

1. Does the hospital provide a mechanism for trauma­related education for nurses involved in trauma care? (CD 17­4) Type II / L1­3 (Yes/No)
2. Is there any hospital funding for physician, nursing or EMS trauma education? (Yes/No)

* If 'Yes', briefly describe:

1. Describe the trauma education program, including examples (list no more than 3 examples of each) for:
2. Physicians:
3. Nurses:
4. Prehospital providers:

**XVIII. PREVENTION**

1. Does the trauma center demonstrate the presence of prevention activities that center on priorities based on local data? (CD 18-1) Type II / L1­4 (Yes/No)
2. What are the three leading causes of injury in your community?
3. Does the trauma center have someone in the leadership position that has injury prevention part of his or her job description? (CD 18­2) Type II / L1­4 (Yes/No)
4. Is universal screening for alcohol performed and documented on 80% of injured patients who are admitted with a hospital stay of >24 hours? (CD 18-3) Type II / L1-4 (Yes/No)
5. Which screening instrument and cutoff scores are being used? (Check all that apply)

* If BAC was selected, please enter cutoff score:
* If ‘Consumption’ was selected, please enter cutoff score: questions
* If ‘AUDIT’ was selected, please enter cutoff score:
* If ‘CAGE’ was selected, please enter cutoff score:
* If ‘CRAFFT’ was selected, please enter cutoff score:
* If ‘Other’ please describe;

1. How do you track compliance with screening of all injured trauma patients?
2. Have all patients who have screened positive received an intervention by an appropriately trained staff, and is this documented? (CD 18-4)Type II / L1-2 (Yes/No)
3. Is there a lead person from the trauma program overseeing 'alcohol screening and brief intervention'? (Yes/No)
4. Who is the lead for SBI?
5. Have job description available at the time of the site visit as attachment 18­2.
6. What is the mechanism for providing brief intervention? (Check all that apply)
7. Positive screens are referred to trauma nurse/nurse practitioner/physician assistant/social worker
8. Person screening provides intervention for positive screens
9. Positive screens are referred to on-site consult service (psychiatry or psychology or substance abuse counselor)
10. Other (if other, please describe):
11. How do you track compliance with interventions for all patients who screen positive?
12. Are there at least two programs that address the major causes of injury in the community? (CD 18-5) Type II/L1-2

* Briefly summarize the two injury prevention programs:
* Have injury prevention program information available at the time of the site visit as attachment 18-3.

1. Does the trauma center’s prevention program include and track partnerships with other community organizations? (CD 18-6) Type II / L1-2 (Yes/No)

* Provide a list of partnership organizations for injury prevention:

1. Does the trauma registry identify injury prevention priorities that are appropriate for local implementation? (CD 15-4) Type II / L1­4 (Yes/No)

**XX. DISASTER PLANNING**

1. Can the hospital respond to the following hazardous materials?
2. Radioactive (Yes/No)
3. Chemical (Yes/No)
4. Biological (Yes/No)
5. Does the hospital meet the disaster­related requirements of JCAHO or equivalent? (CD 20­1) Type II / L1­4 (Yes/No)
6. Is a trauma panel surgeon a member of the hospital's disaster committee? (CD 20­2) Type II / L1­3 (Yes/No)
7. Are there hospital drills that test the hospital's disaster plan conducted at least twice a year, including actual plan activations that can substitute for drills? (CD 20–3) Type II / L1­4 (Yes/No)
8. Is there at least one drill of the notification system? (Yes/No)
9. Is there at least one drill with an influx of patients? (Yes/No)
10. Is there at least one drill that involves the community plan? (Yes/No)
11. Is there an action review of your drills? (Yes/No)
12. Does the trauma center have a hospital disaster plan described in the hospital’s policy and procedure manual or equivalent? (CD 20­4) Type II / L1­4 (Yes/No)

**XXI. SOLID ORGAN PROCUREMENT**

1. Does the facility have a solid organ procurement program? (Yes/No)

* If 'Yes', how many trauma referrals were made to the regional organ procurement organization the reporting year?

1. How many trauma patient donors in the reporting year?

* Number of donations from meeting brain death criteria and after cardiac death (excluding eyes and skin):

1. Does the trauma center have an established relationship with a recognized OPO? (CD 21­1) Type II / L1­3 (Yes/No)

* Briefly describe how you identify OPO:

1. Are there written policies for triggering notification of the OPO? (CD 21­2) Type II / L1­3 (Yes/No)
2. Does the PIPS process review the solid organ donation rate annually? (CD 16­9) Type II / L1­3 (Yes/No)  
     
   ***For further clarification, refer to Chapter 16 in the Resources*** ***Manual.***

* The number of trauma deaths vs. number of organ donation referrals vs successful donations:

1. Are there written protocols defining the clinical criteria and confirmatory tests for the diagnosis of brain death? (CD 21–3) Type II / L1­4

* Briefly describe the protocols and who is privileged to declare brain death:

**Appendix #1 ­ Trauma Medical Director (TMD)**

1. Name:  
   (First name Last name Only; do not include Dr., M.D., or D.O.)
2. Medical School:
   * Year Graduated:
3. Type of Residency:
4. Post graduate training institution (residency):
   * Year Completed:

|  |  |  |
| --- | --- | --- |
| Fellowships | Where Completed (Institution) | Year Completed |
| Trauma |  |  |
| Surgical Critical Care |  |  |
| Pediatric Surgery |  |  |
| Other |  |  |

1. Board Certified: (Yes/No)
   * If ‘Yes’, year of current certification (enter expiration date):
   * Specialty:
2. List added qualifications/certifications giving the Specialty and date received:
3. Is the TMD a Fellow of the American College of Surgeons? (Yes/No)
4. ATLS current: (Yes/No)  
    Highest Level:
   1. Instructor
   2. Provider
5. Trauma CME - External (36 hours, 12 accumulated annually within the last three years):
6. Trauma admissions per year:
7. Number of admits where ISS > 15 per year:
8. Trauma-related Societal Memberships (check all that apply)
   1. AAST
   2. EAST
   3. WST
   4. State COT Chair or Vice Chair
   5. Other
      * If ‘Other’, please list:
9. Number of non-trauma operative cases per year:
10. Number of trauma operative cases per year (Trauma operations limited to those requiring spinal or general anesthesia in the operating room).

**Appendix #2 ­ Trauma Surgeons**

Please list all surgeons currently taking trauma call. This includes surgeons who are seeking or previously approved through Alternate Pathway (AP).

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Name** | **Residency (where and when completed** | | **Board Certification (type and expiration year)  S=American Board of Surgery**  **DO=Osteopathic Surgery**  **CC=Critical Care**  **PS=Pediatric Surgery** | | **ATLS**  **Instructor/Provider**  **Status & Date of Expiration**  **P=Provider**  **I=Instructor  (CD 6–9) Type II / L1-3)** | | **Frequency of trauma calls per month (Days)** | **Number of trauma patients admitted per year** | **CMEs (external / internal and/or trauma related)**  **Alternate Pathway (AP) Only** | **Number of Operative Cases per year** | | **% Attendance at PI Meeting (>50%)** |
|  | Where | When | Type | **Expiration Year** | Status | Expiration Date |  |  |  | Trauma | Non-Trauma |  |
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**Appendix #3 – Trauma Bypass Occurrences**

Please complete if you have gone on trauma bypass during the previous year:

|  |  |  |  |
| --- | --- | --- | --- |
| **Date of Occurrence** | **Time of Bypass Occurred** | **Time Bypass Ended** | **Reason for Bypass** |
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1. Total number of occurrences of bypass (diversion) during reporting period:
2. Total number of hours on bypass (diversion) during reporting period:
3. What is the percentage of time on bypass (diversion)?

**Appendix #4 ­ Neurosurgeon Liaison to the Trauma Program**

1. Name:  
   (First name Last name Only; do not include Dr., M.D., or D.O.)
2. Medical School:
   * Year Graduated:
3. Post graduate training institution (residency):
   * Year Completed:
4. Type of Fellowship:
   * Year Completed:
5. Board Certified: (Yes/No)
   * If ‘Yes’, year of current certification (enter expiration date):
6. Ever ATLS certified? (Yes/No)  
   ATLS Level:
   1. Instructor
   2. Provider
   3. None
7. FACS: (Yes/No)
8. Trauma-related Societal Memberships (check all that apply)
   1. American Association of Neurological Surgery (AANS)
   2. Congress of Neurological Surgery (CNS)
   3. Other
      1. If ‘Other” list other societal memberships:

**Appendix #5 ­ Neurosurgeons**Please list all neurosurgeons taking trauma call. This includes surgeons who are seeking or previously approved through Alternate Pathway (AP).

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Name** | **Residency  (where and when completed)** | | **Board Certification**  **(type and expiration year)** | | **ATLS**  **Instructor/Provider**  **Status & Date of Expiration**  **P=Provider**  **I=Instructor** | | **Frequency of trauma calls per month (Days)** | **Number of Trauma Craniotomies per year** | **CMEs (external / internal and/or trauma related) Alternate Pathway (AP) Only** |
|  | Where | When | Type | Expiration Year | Status | Expiration Date |  |  |  |
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**Appendix #6 ­ Orthopaedic Liaison to the Trauma Program**

1. Name:  
   (First name Last name Only; do not include Dr., M.D., or D.O.)
2. Medical School:
   * Year Graduated:
3. Post graduate training institution (residency):
   * Year Completed:
4. Type of Fellowship:
   * Year Completed:
5. Board Certified: (Yes/No)
   * If ‘Yes’, year of current certification(enter expiration date):
6. Ever ATLS certified? (Yes/No)  
   ATLS Level:
   1. Instructor
   2. Provider
   3. None
7. FACS: (Yes/No)
8. Trauma-related Societal Memberships (check all that apply)
   1. Orthopaedic Trauma Association (OTA)
   2. American Academy of Orthopaedic Surgery (AAOS)
   3. Other
      1. If ‘Other’ list other societal memberships:

**Appendix #7 ­ Orthopaedic Surgeons**Please list all orthopaedic surgeons taking trauma call and/or those who have completed an Orthopaedic Trauma Fellowship (OTA):

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Name** | **Residency  (where and when completed)** | | **Board Certification**  **(type and expiration year)** | | **ATLS**  **Instructor/Provider**  **Status & Date of Expiration**  **P=Provider**  **I=Instructor** | | **Frequency of trauma calls per month (Days)** | **CMEs (external / internal and/or trauma related) Alternate Pathway(AP) Only** | **OTA Fellowship** | | |
|  | Where | When | Type | Expiration Year | Status | Expiration Date |  |  | Where\* | When | Length |
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**Appendix #8 ­ Emergency Medicine Liaison to the Trauma Program**

1. Name:  
   (First name Last name Only; do not include Dr., M.D., or D.O.)
2. Medical School:
   * Year Graduated:
3. Post graduate training institution (residency):
   * Year Completed:
4. Board Certified in Emergency Medicine: (Yes/No)
   * If ‘Yes’, year of current certification (enter expiration date):
5. Ever ATLS certified? (Yes/No)  
    ATLS Level:
   1. Instructor
   2. Provider
   3. None
6. Complete if board certified in another specialty, such as Family practice, internal medicine, etc (Yes/No)
   * If ‘Yes’, please specify:
   * Year of current certification (enter expiration date):
   * Current ATLS: (Yes/No)
     1. ATLS Level
        1. Instructor
        2. Provider
        3. None

**Appendix #9 ­ Emergency Medicine**Please list all emergency departments physicians on the trauma panel

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Name** | **Residency  (where and when completed)** | | **Board Certification**  **(type and expiration year)** | | **ATLS**  **Instructor/Provider**  **Status & Date of Expiration**  **P=Provider**  **I=Instructor** | | **Number of shifts per month** | **Length of shifts** | **CMEs (external / internal and/or trauma related) Alternate Pathway(AP) Only** |
|  | Where | When | Type | Expiration Year | Status | Expiration Date |  |  |  |
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**Appendix #10 ­ Anesthesiologist Liaison to the Trauma Program**

1. Name:  
   (First name Last name Only; do not include Dr., M.D., or D.O.)
2. Medical School:
   * Year Graduated:
3. Post graduate training institution (residency):
   * Year Completed:
4. Fellowship:
   * Year Completed:
5. Board Certified by the American Board of Anesthesiology: (Yes/No)
   * If ‘Yes’, year of current certification (enter expiration date):
6. Ever ATLS certified? (Yes/No)

ATLS Level:

* 1. Instructor
  2. Provider
  3. None

**Appendix #11a – PIPS Committee- MULTIDISCPLINARY TRAUMA PEER REVIEW**

**Performance Improvement and Patient Safety (PIPS) COMMITTEES**

**MULTIDISCIPLINARY TRAUMA PEER REVIEW**

The hospital’s Multidisciplinary Trauma Peer Review Committee which improves trauma care by reviewing selected deaths, complications, and sentinel events with objective identification of issues and appropriate responses (CD5.18, CD5.19, CD5.20, and CD5.21)

1. Name of Committee:
2. What is the purpose of the committee? Multidisciplinary Peer Review
3. Name / Title of Chairperson:
4. How often does this committee meet?
5. Attendance of specialty panel members:

\*Applies to Level I adult and Level II peds or Level II adult and Level II peds or Level I or II peds

|  |  |
| --- | --- |
| Pediatric TMD: | % |
| Pediatric TPM: | % |
| Pediatric Trauma Surgeons: | Refer to appendix #2 |
| Pediatric Emergency Medicine Liaison or Designated Representative: | % |
| Pediatric Neurosurgery Liaison or Designated Representative: | % |
| Pediatric Orthopaedics Liaison or Designated Representative: | % |
| Pediatric Anesthesiologist Liaison or Designated Representative: | % |
| Pediatric Radiologist Liaison or Designated Representative: | % |
| Pediatric ICU Director Liaison or Designated Representative: | % |

1. Committee reports to whom?

**Appendix #11b – PIPS Committee - Multidisciplinary Trauma Systems / Operations Committee**

**Performance Improvement and Patient Safety (PIPS) COMMITTEES**

**Multidisciplinary Trauma Systems/Operations Committee**

TRAUMA PROGRAM OPERATIONAL PROCESS PERFORMANCE COMMITTEE   
(previously named Multidisciplinary System Committee)

1. Name of Committee at your institution:
2. What is the purpose of the committee? Multidisciplinary Trauma Systems/Operations
3. Name / Title of Chairperson
4. Are there attendance requirements?
   1. If “Yes’ describe
5. Attendance of specialty panel members

\*Applies to Level I adult and Level II peds or Level II adult and Level II peds or Level I or II peds

|  |  |
| --- | --- |
| Pediatric TMD | % |
| Pediatric TPM | % |
| Pediatric Trauma Surgeons | % |
| Pediatric Emergency Medicine | % |
| Pediatric Neurosurgeons | % |
| Pediatric Orthopaedics | % |
| Pediatric Anesthesiologist | % |
| Pediatric Radiologist | % |
| Pediatric ICU Director | % |
| Other Attendees | % |

1. Committee reports to whom?

**Appendix #12 ­ Radiologist Liaison to the Trauma Program.**

1. Name:  
   (First name Last name Only; do not include Dr., M.D., or D.O.)
2. Medical School:
   1. Year Graduated:
3. Post graduate training institution (residency):
   1. Year Completed:
4. Fellowship:
   1. Year Completed:
5. Board Certified by the American Board of Radiology: (Yes/No)
   1. If ‘Yes’, year of current certification (enter expiration date):
6. Ever ATLS certified? (Yes/No)  
    ATLS Level:
   1. Instructor
   2. Provider
   3. None

**Appendix #13 ­ Surgical Critical Care Liaison to the Trauma Program**

1. Name:  
   (First name Last name Only; do not include Dr., M.D., or D.O.)
2. Medical School:
   * Year Graduated:
3. Type of Residency:
4. Post graduate training institution (residency):
   * Year Completed:

|  |  |  |
| --- | --- | --- |
| Fellowships | Where Completed (Institution) | Year Completed |
| Trauma |  |  |
| Surgical Critical Care |  |  |
| Pediatric Surgery |  |  |
| Other |  |  |

1. Board Certified: (Yes/No)
   * If ‘Yes’, year of current certification (enter expiration date):
2. Specialty:
   * List added qualifications/certifications giving the Specialty and date received:
3. Is a Fellow of the American College of Surgeons? (Yes/No)
4. ATLS current: (Yes/No)  
    Highest Level:
   1. Instructor
   2. Provider

**Appendix #14 ­ Pediatric TMD**

1. Name:  
   (First name Last name Only; do not include Dr., M.D., or D.O.)
2. Medical School:
   * Year Graduated:
3. Type of Residency:
4. Post graduate training institution (residency):
   * Year Completed:

|  |  |  |
| --- | --- | --- |
| Fellowships | Where Completed (Institution) | Year Completed |
| Trauma |  |  |
| Surgical Critical Care |  |  |
| Pediatric Surgery |  |  |
| Other |  |  |

1. Board Certified: (Yes/No)
   * If ‘Yes’, year of current certification (enter expiration date):
2. Specialty:
   * List added qualifications/certifications giving the Specialty and date received:
3. Is the TMD a Fellow of the American College of Surgeons? (Yes/No)
4. ATLS current: (Yes/No)  
    Highest Level:
   1. Instructor
   2. Provider
5. Trauma CME - External (36 hours, 12 hours accumulated annually, in which 9 hours should be pediatric specific within the last three years):
6. Trauma admissions per year:
7. Number of admits where ISS > 15 per year:
8. Trauma-related Societal Memberships (check all that apply)
   1. AAST
   2. EAST
   3. WST
   4. State COT Chair or Vice Chair
   5. Other
      * If ‘Other’ please list
9. Number of non-trauma operative cases per year:
10. Number of trauma operative cases per year (Trauma operations limited to those requiring spinal or general anesthesia in the operating room).

**Appendix #6-1**

**Alternate Pathway Criteria (APC) for Non–Board-Certified Surgeons/Physicians**

1. Name:  
   (First name Last name Only; do not include Dr., M.D., or D.O.)
2. Seeking APC for:
   * Trauma Surgeon
   * Neurosurgeon
   * Orthopaedic Surgeon
   * Emergency Medicine
3. New and / previously approved (Yes/No)
4. Medical School:
   * Year Graduated:
5. Post graduate training institution (residency):
   * Year Completed:

Note: Time period should be consistent with the number of years of training in the U.S.

1. Fellowship
   * Type / Year Completed:
2. Board Certified: (Yes/No)
   * Where:
   * Year of current certification (enter expiration date):
3. Fellow of the American College of Surgeons: (Yes/No)
4. Royal College of Physicians and Surgeons of Canada: (Yes/No)
5. ATLS certified / Expiration Date: (Yes/No)  
   ATLS Level:
   1. Instructor
   2. Provider
   3. None
6. Trauma-related Societal Memberships:
7. Number of trauma-related CME - External  (36 hours, 12 hours accumulated annually, within the last 3 years, or through participation in an equivalent number of hours in the trauma center’s internal education process (IEP), or a combination of CME and IEP):
8. Attendance at the multidisciplinary trauma PIPS meeting (>50%):
9. Licensed to practice medicine with full and restricted surgical privileges:
10. Does the TMD perform a PIPS assessment on the morbidity and mortality results for patients treated by this surgeon/physician?
11. Please briefly describe:

The following will be reviewed onsite by an ACS reviewer from the same specialty:

* Please ensure a copy of the applicant’s CV is sent to the VRC office well in advance to ensure that s/-he meets the APC.
* All the above is required to be available onsite at the time of the site visit.
* A list of patients treated during the past year with accompanying Injury Severity Score and outcome data.
  + A request will be sent to the hospital for this information.

**If there are additional surgeons applying for the Alternate Pathway, please download a copy of the form on the website at** [**https://www.facs.org/quality-programs/trauma/vrc/resources**](https://www.facs.org/quality-programs/trauma/vrc/resources) **and submit it separately.**