

REVIEW AGENDA

The purpose of the American College of Surgeons Consultation/Verification review process is to verify a hospital's compliance with ACS standards for a trauma center. Site surveyors are charged with the responsibility of obtaining a detailed and accurate assessment of a hospital's capabilities in a very short period of time. For this reason, we ask that the trauma program personnel at the hospital carefully prepare for the site visit by having all documents and medical records carefully organized and accessible to the surveyors. Please be aware that surveyors will look beyond the requested documents and medical records if they need additional validation of compliance with the standards. The Pre-Review Questionnaire (PRQ) provides surveyors an overview of the trauma program and serves as a guide for the review process.

For planning purposes, the review will last approximately six to eight hours over a two day period. Do not prepare your own agenda or presentation. A typical agenda for the site visit, Day #1 – chart review and evaluation of PI starting around 1pm followed by the Pre-Review dinner/meeting beginning at approximately 6:00-6:30pm. Day #2 – hospital tour starting at 7am, further chart review and evaluation of PI; review of other documentation; site survey team Closed Meeting (30-60) minutes, and finish with the Exit Interview approximately between 10-12pm. Due to flight schedules and arrival times, the surveyors may not be able to review charts prior to the pre-review meeting/dinner and will begin chart review the morning of the second day of the review. The lead reviewer will coordinate the format with the hospital (trauma program manager) and the survey team.

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

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

Note: A pre-review meeting/dinner is mandated, however, a formal or informal dinner is not required.

TOUR

Reviewers will determine the start time and specifics of the tour. Please arrange for trauma team members to guide each reviewer and have staff available to meet with the reviewers in each department during the tour. It is helpful for the trauma program manager, trauma registrar, and trauma medical director to be readily available to the survey team for the entire review. One of the reviewers will visit each department listed below, not necessarily in the order stated.

A. Emergency Department

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

B. Radiology

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

C. Operating Room/PACU

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

D. ICU / PICU

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

E. Blood Bank

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

F. Rehabilitation

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

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

Potential interviews include:

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

H. Chart Review/PIPS (refer to list on page 4-5)

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

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

J. Exit Interview

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

While the American College of Surgeons Committee on Trauma (ACS COT) does not have any specific guidelines regarding attendees at the Exit Interview, the Exit Interview is considered to be confidential and the hospital may wish to construct its attendance list carefully.

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

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

Deficiencies are determined by the guidelines found in the current edition of the document *Resources for Optimal Care of the Injured Patient* and additional information provided to you prior to this visit.

The confidential report will be sent to the Verification Review Committee office in Chicago and then forwarded to the members of the Verification Review Committee. The final decisions regarding deficiencies will be made by the Verification Review Committee, and may differ from the findings that we are about to report. **The final report will be provided to the hospital between 30-60 days after the initial site visit.**

MATERIALS REQUIRED AT TIME OF REVIEW

All materials requested are to be available on site in a room where the chart review will take place. A room with conference style table and adequate space for surveyors to comfortably complete the review of the medical records should be available.

A. Documentation of the hospital's trauma activity for during the review period

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

*For Level I trauma centers and/or Level I Pediatric Trauma Centers, the Research Form must be completed for each article being considered for the requirement,
<http://www.facs.org/trauma/vrcresearchform.pdf>

B. Copy of call/backup schedule for 3 months during the review period

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

C. Documentation of CME (Level I & Level II trauma centers)

1. The trauma medical director must have 16 hours per year and 48 hours for 3 years of verifiable external CME. The same is true for the liaisons from neurosurgery, orthopaedic surgery, and emergency medicine. Visiting professors and invited speakers are all considered external CME. Please have copies of the certificates available onsite the surveyors may spot check the certificates to verify this.
2. Other members of the trauma team including the above specialties need to be knowledgeable and current in the care of trauma patients. This requirement must be met by acquisition of 16 hours of CME per year on average – or – by demonstrating participation in an internal educational process conducted by the trauma program based on the principles of practice-based learning and the PIPS program. Examples are available on the Frequently Asked Questions document, http://www.facs.org/trauma/faq_answers.html.

In preparation for the site review, the hospital should demonstrate how the physicians received CME. This can be done by attendance sheets from trauma related conferences, meetings, certificates from computer based programs, documentation of articles that were read, etc.

D. Performance Improvement and Patient Safety (PIPS)

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

E. Medical Records – available at the time of the review

For those trauma centers that are seeking separate pediatric verification, please insure a second set of charts, same categories as adult, for patients less than 15 years of age are available onsite.

Medical records must be pulled for the review period/reporting period (should not be older than 14 months prior to the scheduled survey date) as identified in the hospital's Pre-Review Questionnaire (PRQ).

For paper medical records; include a face sheet with the following information:

1. Pre-hospital run sheet w/ISS
2. Minutes
3. Progress/specialty notes.
4. Performance Improvement and other related information
5. Be prepared to extract data from the trauma registry upon the site surveyors' request.

Electronic medical records (EMR), there must be a computer available for each of the site surveyors with an assigned staff member that is proficient and knowledgeable in the electronic medical record system for each of the surveyors.

For centers that have EMR, the following must be available onsite:

1. Pre-hospital – a)EMS run sheet w/ISS, b)Transferring facility ED info
2. Trauma Flow Sheet
3. H & P
4. Consults
5. Op notes
6. Discharge Summaries
7. Autopsy reports
8. Copies of PI documentation and other related information
9. Be prepared to extract data from the trauma registry upon the site surveyors' request.

With regard to the trauma PI program, pull the last 30 trauma deaths. Based on your Mortality Conference, separate the charts into the categories listed below. Each stack should be labeled accordingly.

- Unanticipated mortality with opportunity for improvement
- Anticipated mortality with opportunity for improvement
- Mortality without opportunity for improvement

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

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

*An adverse event is usually an error that leads to major complication or death.

Note: It is possible that some charts may fall into the same categories. Do not copy the chart, place the chart in the category deemed appropriate.

The last 10 charts for trauma patients admitted to non-surgical services. Examples of non-surgical services include internal medicine, neurology, pediatric, family practice, hospitalist and geriatric medicine.

If the non-surgical admissions are more than 10% of the total admissions, in addition to pulling the last 10 admits to non-surgical services, breakdown of how many of those patients met the following criteria:

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

REPORT

The report follows the same process as a standard verification/reverification/consultation report.

Phase I	Phase II	Phase II	Phase IV	Phase V
Team submission	Office Receipt	Editor Review	VRC Vetting	Chair Ruling

This process can take up to 8 to 10 weeks to when the hospital will receive the final letter and report.



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