

# 2011 Site Surveyor Orientation Guide

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Dear Site Surveyors:

Thank you for agreeing to be a trauma center site surveyor for the Pennsylvania Trauma Systems Foundation (PTSF). A PTSF survey team must accomplish many tasks during the site survey. The surveyors' review is based on the PTSF Standards for Trauma Center Accreditation. Because your knowledge of Pennsylvania's process may be limited, we would like to provide this orientation prior for your arrival in Pennsylvania.

While there may be some similarities between the PTSF trauma center accreditation process, the ACSCOT Verification process, and other state and regional trauma designation processes, each process is unique in its own way. This packet contains information about Pennsylvania's site survey process and your role as a site surveyor. It is updated every year to reflect site surveyor comments and staff observations.

Please read this packet carefully. It will prepare you in advance for how the site survey will proceed and serve to familiarize you with the many facets of a process which seeks to ensure that trauma patients are being well cared for at the facility under review. This information will be reinforced during our evening orientation together at which time you will get hands on training regarding our surveyor software screens so that you will feel comfortable in your role.

There is also an opportunity for web-based education that will familiarize you with our new Electronic Application for Survey (eAFS).

Thank you for sharing your expertise with us as we strive to evaluate and improve trauma care in Pennsylvania's trauma centers. You can be assured that PTSF staff will attentive throughout the entire process to support your needs in whatever way possible.

Please don't hesitate to call us with any questions; we look forward to working with you.

Sincerely,

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## Site Survey Team Orientation

Prior to attendance at the Site Survey Team Orientation, it is the responsibility of each surveyor to thoroughly review the institution's Electronic Application for Survey (see Appendix A for instructions).

The evening prior to the first survey day, Pennsylvania Trauma Systems Foundation (PTSF) staff will provide an orientation for the survey team that outlines the survey process and the Site Survey Software. This orientation ensures that all site survey visits are conducted in a standardized and provides a forum for any questions related to the site survey process, the Pennsylvania Trauma Systems Foundation or the Standards for Trauma Center Accreditation will be answered.

- **NOTE: All survey team members are required to attend. Dress is business casual unless otherwise advised. Dinner will be served following the orientation meeting.**

Please inform PTSF staff if your arrival will be delayed by contacting one of our cell phones:

Kevin Burd	(717) 576-6194
Susan Werner	(717) 585-1709

During the orientation the following information will be reviewed:

- The authority, responsibility and operations of the PTSF
  - Standards for Trauma Center Accreditation
  - Team member roles and responsibilities
  - Agenda for survey day
  - The Site Surveyor Evaluation Book, including: Trauma registry information; Areas for Further Review (AFR), if applicable; Significant Issues, if applicable; Summary Comments Pages (electronic)
  - The Site Survey Software computer program and process for medical record review
- **NOTE: PTSF staff members will not share the survey history of an institution unless that history is included by the trauma center in their Application for Survey.**

## Survey Specifics

**Travel, Hotel Accommodations, Meals:** Each surveyor will receive an agreement that outlines the provisions for services as an independent contractor prior to the trauma accreditation survey. This agreement outlines your responsibilities as a surveyor, your compensation, services provided by PTSF staff, travel arrangements and several attachments which must be completed and returned.

## Additional Information for Site Surveyors

We encourage all surveyors to call the PTSF office with any questions related to the survey process or accessing the Electronic Application for Survey (EAFS). Listed below are staff resources based on your question:

Technical Assistance: Nathan McWilliams 717-697-5512 ext. 106

Content Assistance: Susan Werner 717-697-5512 ext. 102  
717-585-1709 (cellular)

Kevin Burd 717-697-5522 ext.104

Additionally we will be providing Webinars for group education prior to the site survey. Opportunities will be sent to you via email.

## Site Survey Confidentiality and Conduct

The credibility of the survey process depends on the consistency, thoroughness, accuracy and objectivity of the survey team and Foundation staff.

### Confidentiality:

The Foundation maintains the confidentiality of all applicant hospitals' status in the accreditation cycle and all information obtained during the accreditation process.

- Do not discuss any information related to the individual hospital with anyone other than Foundation Staff.
- Do not reveal the name of, or refer to other hospitals you are reviewing during comments or in response to questioning by other hospitals that you are surveying
- Ask questions; do not make assumptions about the survey process or hospital information and practices. Foundation and hospital staff members are available all day to answer your questions and to assist you in your review.
- Engage in dialogue with trauma center staff regarding any unclear or substandard care practices or information you are unable to locate.
- Please do not ask hospital staff, "What can I do for you?" or "What do you want me to include in my report?"
- Avoid making unnecessary comments and rendering personal opinions.
- Avoid discussing your opinion of the appropriateness or intent of the Standards.
- Do not spend too much time on one issue, one medical record or linger on the tour.
- Be friendly and courteous.

### Conduct:

Surveyors will maintain exemplary standards of professional and interpersonal conduct, including all contact with members of hospital administration and staff and all members of the survey team regardless of whether those persons are directly involved in the hospital survey or consultative visit.

- **NOTE: The Foundation encourages open dialogue between survey team members and hospital staff. We are there also to assure that the day is proceeding in a timely way and will intercede if necessary to maintain the day's agenda.**

## Site Surveyor Information Book

A survey information book will be provided to you for each hospital. This book will contain your updated Itinerary, Significant Issues (including assignments to specific surveyor/s if appropriate), Hospital Specific Data and a copy of the assigned queries.

It is recommended that you familiarize yourself with your Standards assignments, the contents of those Standards and the Significant Issues that have been assigned to you.

### The survey information book includes:

- TAB I—Itinerary: This will be updated from the one received in your earlier mailing.
- TAB II—Significant Issues (if applicable): Significant Issues are items identified from the institution's previous site survey. The Board of Directors needs to know if these issues have been addressed as a measure of the institution's commitment to the trauma program. These issues will be assigned according to surveyor specialty and a response is required in the site survey software.
- TAB III—Hospital-Specific Data: Trauma Registry Data from the Pennsylvania Trauma Outcome Study (PTOS) trauma registry will be provided for your information. The institution will have available for you additional trauma registry data, reports and information on the day of site survey.
- TAB VI—Queries: The PTSF Board of Directors has established some standard queries that will be assigned to each surveyor prior to site survey day.
- Tab V—Templates: Examples of Significant Issues and Summary Comments.

### Compliance with the Standards is based on the following:

- Review of available documentation, including trauma center policies and procedures,
- Interviews with hospital staff,
- Review of medical records,
- Review of performance improvement documentation,
- Information obtained during the hospital tour, and
- Review of the institution's Application for Survey.

It is your responsibility, using information obtained during the site survey, to indicate if the hospital is in compliance with the Standard(s). If the hospital does not meet the Standard(s), identify the reason(s) in the summary comment section of the site survey software.

## Accreditation Visits

The purpose of the accreditation visit is to determine a hospital's compliance with Pennsylvania Trauma Systems Foundation Standards for Trauma Center Accreditation. Site surveys are conducted according to the *Standards for Trauma Center Accreditation* and the *Standards for Pediatric Trauma Center Accreditation*, which are based on the American College of Surgeons guidelines for trauma center accreditation.

### Compliance with the Standards is demonstrated by:

- Appropriate and timely clinical management of the trauma patient as documented in the medical record.
- Trauma center/system performance improvement, use of the POPIMS software, and the integration into the institution's performance improvement program.
- Policies, procedures, protocols and patient management guidelines for the clinical and fiscal administration of the trauma program/center.
- Education and training of the trauma center personnel in clinical management of the trauma patient.
- Integration of the Standards for trauma center accreditation into the operation of the trauma program.

### Measurement of compliance is based on:

- Documentation of appropriate and timely clinical management of the trauma patient.
- Demonstration that the trauma performance improvement program identifies, analyzes, and documents information into the POPIMS software; clinical and systems issues and incorporating them into the hospital wide performance improvement program.
- Documentation of policies, procedures, protocols, and patient management guidelines.
- Interviews with individuals participating in the trauma care system.
- Documentation of compliance with Standards as evidenced by the Institution's Application for Survey (AFS).

The PTSF Board of Directors is the decision-making body regarding trauma center accreditation in Pennsylvania. The Board utilizes surveyors as its fact-finding team to determine if compliance with the standards is documented.

## Consultative Visits

Hospitals pursuing their initial accreditation are encouraged to undergo a consultative visit the year prior to the formal site survey. You will be notified if the hospital you have been scheduled to review is undergoing a consultative visit rather than a formal site survey. The consultative visit mirrors the formal site survey in every respect except:

1. The number of medical records that are reviewed is reduced to allow adequate time for increased dialogue and education from the site survey team.
2. The Board of Directors does not make an accreditation determination, although there is surveyor input into the site surveyor software.
3. Results from the consultative visit are not shared with the formal site survey accreditation team.

## Accreditation Process

### Pre-Survey

- Each trauma center scheduled for site survey completes a web-based Electronic Application for Survey (eAFS).
- Foundation staff completes a preliminary review of the eAFS and notifies the hospitals if clarification is required. If clarification is required, the hospital makes the necessary changes and PTSF staff conducts a secondary review. If the updated information does not provide the necessary clarification or is not compliant with PTSF standards, PTSF advises the Site Surveyor to assure further investigation of any required clarification on site survey day.
- Site survey team reviews the institution's Application for Survey, PTSF standards for trauma center accreditation, and any other preparation materials forwarded by PTSF staff to the surveyor.

### Site Survey Season (April - August)

- Applicant hospitals are surveyed by survey teams determined by PTSF.

### Post-Survey Season (July - November)

- Foundation staff prepares the documents that will be reviewed by the Board of Directors during the accreditation deliberation meeting. All hospital identifiers are redacted to insure anonymous review.
- The PTSF Board of Directors reviews each individual hospital's materials and makes an accreditation status decision based on a majority vote. A strict conflict of interest (COI) policy is enforced to assure that Board members residing or working in the county where the trauma center is located are not involved in deliberations for that hospital.
- An accreditation report is sent to the Chief Executive Officer at each applicant hospital. The report contains Significant Issues identified by the PTSF Board of Directors, Opportunities for Improvement, Areas of Strength, and individual medical record reviews. The frequency of site surveys is based on the number and severity of significant issues cited.
- PTSF staff members conduct meetings with trauma centers to review the reports and assist in action plan development.

## **PTSF Support of Trauma Centers Preparing for Site Survey**

### **I. Written/Electronic Materials**

All trauma centers receive an electronic copy of “The Site Survey Guidebook” to assist them with preparations for the site survey. This document explains the site survey process and includes:

- A detailed outline of the time schedules
- Participant lists for meetings throughout the day
- Potential questions that may be asked during the physician and nursing group meeting
- Information and materials required for review by the survey team prior to and during the survey day
- Suggestions on how to prepare Performance Improvement and Significant Issue information
- Medical records selection criteria, and
- Site survey team member responsibilities.

### **II. PTSF Education**

PTSF conducts several conferences per year reviewing expectations for site survey. New trauma coordinators and medical directors are provided with group and one on one education as necessary. As trauma program staffs change, PTSF conducts on site educational visits to discuss the goals of the Pennsylvania trauma system and the preparations necessary for the site survey process. Additionally, many hospitals hire consultants to assist them if issues are ongoing and extra help is needed to correct them.

## Site Survey Team Responsibilities

### ***All Team Members***

- Complete a thorough patient medical record and performance improvement review based on your area of clinical expertise following the procedures outlined in this orientation packet and as directed by Foundation staff.
- Resolve Areas for Further Review from the AFS
- Comment on the status of Significant Issues identified from the previous site survey
- Make summary comments on the overall trauma program, performance improvement program and strengths and opportunities for improvement using the supplied template.
- Participate in the Leadership meeting. Discuss any substandard clinical practices for which loop closure is either inappropriate or not thoroughly documented in performance Improvement records with the trauma program staff. Document these discussions in the site survey software.

### ***Trauma Surgeon Team Leader***

- Facilitate team discussions during break times.
- Participate in and facilitate the physician group meeting.
- Participate in the performance improvement review of the overall trauma program.
- Lead the Leadership meeting.

### ***Trauma Surgeon(s)***

- Participate in the physician group meeting.
- Review content-specific patient care as assigned with focus on PI integration.
- Participate in the performance improvement review of the overall trauma program.
- Participate in the Leadership meeting

### ***Neurosurgeon, Orthopedic Surgeon, Emergency Physician***

- Participate in the physician group meeting.
- Review content-specific patient care as assigned with focus on specialty issues
- Participate in the performance improvement review of the overall trauma program.
- Participate in the Leadership meeting

### ***Registered Nurse***

- Participate in and facilitate the nursing group meeting.
- Participate in the focused performance improvement review of the trauma program relevant to nursing and multidisciplinary issues as explained in the institution's Application for Survey.
- Participate in the Leadership meeting

## Time Schedule

You will receive specific time schedules for each institution you will visit. Time schedules vary slightly based on the institution’s location or status in the accreditation cycle. Standard times are noted on the following pages after each section of the time schedule. These times will give you a general idea of the amount of time allotted for each part of the survey day.

### New Applicant, Provisional, Two-Year & Three-Year Site Survey Schedule

6:45 a.m. to 7 a.m.	Survey Team Arrival & Brief Introductions
7 a.m. to 7:15 a.m.	Opening Conference by Trauma Center Staff
7:15 a.m. to 8 a.m.	Physician and Nurse Group Meeting
8 a.m. to 8:45 a.m.	Significant Issue/Performance Improvement Review
8:45 a.m. to 9:15 a.m.	Hospital Tour
9:15 a.m. to 9:30 a.m.	Medical Record Orientation
9:30 a.m. to Noon	Medical Record Review
Noon to 12:45 p.m.	Lunch (Private)
12:45 p.m. to 1:00 p.m.	Binder Review (see page 33 for description)
12:45 p.m. to 4 p.m.	Medical Record Review (20-30 minutes of this time will be allotted for the review of standardized queries)
4 p.m. to 5:30 p.m.	Survey Team Conference
5:30 p.m. to 6 p.m.	Leadership Meeting

### One-Year Site Survey Schedule

6:45 a.m. to 7 a.m.	Survey Team Arrival and Brief Introductions
7 a.m. to 8:00 a.m.	Opening comments and Significant Issue/Performance Improvement Review presented collectively to entire survey team.
8:00 a.m. to 8:30 am	Physician/Nurse Group Meetings
8:30 a.m. to 8:45 a.m.	Medical Record Orientation
8:45 a.m. to Noon	Medical Record Review
Noon to 12:45 a.m.	Lunch (Private)
12:45 p.m. to 4 p.m.	Medical Record Review
4 p.m. to 5:30 p.m.	Survey Team Conference
5:30 p.m. to 6 p.m.	Leadership Meeting

**Site Survey Team Arrival (6:45 a.m. – 7 a.m.):**

Survey team arrives to meet the trauma program medical director, trauma program coordinator, trauma program administrator and other trauma program staff. Refreshments are provided by the trauma center.

**Opening Conference (7 a.m. – 7:15 a.m.):**

Foundation staff makes brief opening comments and asks survey team members to introduce themselves (name, title, place of employment and any other opening comments you wish to make). Applicant institutions receive a copy of your biographical sketch prior to the site survey day.

The Chief Executive Officer (CEO)/President/Administrator for the hospital will present unique information about the trauma center that may not be in the Application for Survey. Other suggestions provided include a description of the trauma program. Please ask questions following the presentation for clarification purposes. The trauma performance improvement process should be discussed during the Physician/Nurse Meetings and/or during Significant Issue/ Performance Improvement Review and should be presented to all surveyors.

**Physician/Nursing Group Meeting (7:15 a.m. – 8 a.m.):**

Physician and nursing members of the survey team meet with hospital physician and nursing staff members. The primary goal of this meeting is to obtain information on the trauma team and the interaction among the surgical and non-surgical specialties and the nursing units that provide care for trauma patients. A list of recommended hospital participants (approximately 12-15 for each group) has been distributed to the hospital (Site Survey Guidelines). A member of the Foundation staff may also attend these meetings. *It is recommended that case scenarios be used as a way of allowing staff to describe how the patient is managed from the pre-hospital environment through the continuum of care.*

Do not allow the trauma program medical director/trauma program coordinator to answer all of the questions.

These meetings are facilitated by the Trauma Surgeon Team Leader (physician group meeting) and the Registered Nurse surveyor (nursing group meeting). Please ask all participants to introduce themselves and state their specialty prior to beginning the meeting. Be prepared to ask questions regarding:

- Your review of Significant Issues,
- Information related to PTSF Standard compliance,
- Trauma performance improvement activities, and
- To determine how trauma is integrated into the overall hospital (clinical and PI).

**Physician Group Meeting sample questions**

1. What/how has your specialty changed (trauma clinical practice) since the last site survey?
2. What has your specialty done to resolve a specific significant issue?
3. Describe your relationship with the Trauma Service?
4. Describe any major changes (equipment/personnel/responsibilities related to trauma patient care) within your specific department and/or clinical area.
5. What trauma related Performance Improvement indicators/initiatives were chosen by your department to be monitored?
  - a. Why were they chosen?
  - b. How is this information tracked and/or trended?
  - c. How is this information communicated to the Trauma Service and the other areas of the institution?
6. Describe the development of a clinical treatment plan for a specific type of trauma patient, for example:
  - a. A spinal cord injured patient and the working relationship between the trauma service, neurosurgery, orthopedics and rehabilitation,
  - b. The decision to transfer a severely injured pediatric trauma patient (who makes the decision, clinical criteria that is utilized to make the decision, and the role of the trauma surgeon/emergency medicine/pediatrician),
  - c. A complex pelvic fracture and the working relationship between trauma service, emergency medicine, orthopedics, radiology, or
  - d. The clinical management of the trauma patient's airway and the working relationship between emergency medicine, resident staff, anesthesia, advanced practitioners and the trauma service.
7. Describe the development of a clinical treatment plan for trauma patients in the Intensive Care Unit, for example:
  - a. Ventilator management,
  - b. The role of the ICU service and the relationship with the Trauma Service,
  - c. The role of the 1<sup>st</sup> responder and what clinical scenario requires the physical presence of an attending trauma surgeon
  - d. If a trauma patient has an elevated ICP, who is the first person to receive a phone call and how is this trauma patient "managed" (i.e., 1<sup>st</sup> responder, trauma resident, attending trauma surgeon, neurosurgical resident, and/or the attending neurosurgeon).
8. Describe the relationship with the various EMS agencies for example:
  - a. How clinical information is communicated to the trauma center,
  - b. How clinical and system performance improvement information is shared,
  - c. Describe the "latest" clinical issue that required additional education for a specific EMS agency/provider,
  - d. The role of medical command within the region.
9. Describe the most recent clinical and/or system issue(s) that was identified and resolved by the (your specialty) performance improvement process.

***Nurse Group Meeting sample questions***

1. What/how has your clinical area/unit changed since the last site survey?
2. What has your department/clinical area/unit done to resolve a specific significant issue?
3. Describe your interaction with the Trauma Service.
4. Describe your interaction with the various ancillary department(s) that provides care and treatment for the trauma patient (PT/OT/speech/social work/ nutrition/pharmacy).
5. Describe any major changes (equipment/personnel/responsibilities related to trauma patient care) within your specific department/clinical area/unit,
6. What trauma related Performance Improvement indicators were chosen by your department/clinical area/unit to be monitored?
  - a. Why were they chosen?
  - b. Who collects the information?
  - c. How is this information tracked and/or trended?
  - d. How is this information communicated to the Trauma Service and the rest of the institution?
  - e. Who is responsible for communicating this information?
7. Describe any multidisciplinary PI related activities that occurred since the last site survey.
8. Describe the last “major” clinical and/or system issue that effected trauma patient care in your specific department/clinical area/unit.

***Significant Issue Review/Performance Improvement Review (8 a.m. – 8:45 a.m.):***

Immediately following the physician and nursing group meetings the survey team will review the Significant Issues from the previous site survey. If there are fewer than three significant issues, all issues will be presented to the surveyors as a group. The surveyors will review pertinent information/data/ documentation and/or discuss the issues with hospital staff. Information should be available that will show the review, corrective action, improvement and resolution status of the issue. The issues are assigned to the surveyors according to clinical specialty for comment in the site survey software.

Structure—significant issues are presented to the surveyors as a group. However, if there are a large number of issues, each site surveyor will be assigned to a single table in a pre-designated area and will review information related to their assigned significant issues.

Process—trauma center staff will have a complete list of Significant Issues that includes specific assignments for the entire site survey team. The file/binder/packet of information that details the activities/changes/data/modifications supporting the resolution of each significant issue should be located at the appropriate site surveyor table. Trauma center staff must be available to discuss each Significant Issue.

Desired Outcome—the site surveyors should be able to clearly determine that appropriate action(s) has occurred to demonstrate the resolution of and/or appropriate progress toward the resolution of significant issues.

## Roles of Survey Team Members During Significant Issues/Performance Improvement Session

### Trauma Surgeon Leader

The Trauma Surgeon Leader will discuss specific aspects of the trauma program's performance improvement process with the Trauma Program Medical Director *focused on the previously identified significant issues*. The goal is to understand how the trauma program conducts performance improvement activities. Any question regarding performance improvement may be asked during this time.

Potential areas of discussion could include the following topics:

- Coordinating the trauma performance improvement review process,
- Peer review process - review of minutes, agendas, and follow-up materials for Morbidity and Mortality Conference/Trauma Conference/General Surgery Conference/any forum which reviews trauma patients,
- Clinical decisions regarding the transfer of pediatric trauma patients and the review of care provided to pediatric patients in the ICU,
- Specific pediatric audit filters and the review of pediatric trauma care,
- Pediatric trauma performance improvement,
- Use of trauma patient management guidelines,
- Use of the Trauma Registry,
- Performance improvement indicators/initiatives selected by surgical and non-surgical members of the trauma team and how this information is communicated to all members of the trauma team,
- Any questions regarding overall compliance with PTSF Standards
- Trauma team privileges.
- Any additional performance improvement topics and/or questions identified from the Application for Survey or site survey information.

### Trauma Surgeon

The Trauma Surgeon will meet with an additional trauma surgeon to discuss specific aspects of clinical care. A primary focus of this meeting will be to review the performance improvement process related to unexpected outcomes and clinical occurrences. The intent is to review and discuss the trauma centers overall process and evaluation of unexpected outcomes and clinical occurrences as noted in the Application for Survey.

Additional topics for discussion by the trauma surgeon could include the following:

- All Significant Issue(s) assigned to the Trauma Surgeon,
- Resource utilization and cost effectiveness,
- Trauma care provided in the Intensive Care Unit(s),
- Any questions regarding overall compliance with PTSF Standards
- Any additional performance improvement topics and/or questions identified from the Application for Survey or site survey information.

## **Registered Nurse**

The Registered Nurse will meet with the trauma program manager to discuss the overall integration of trauma nursing performance improvement throughout the hospital and the general review of performance indicators as identified in the EAFS. At this time the registered nurse will identify at least two types of indicators to review in detail. If time is not available this can occur during the afternoon session.

Additional topics of discussion could include the following:

- All Significant Issue(s) assigned to the Registered Nurse,
- Coordination of nursing performance improvement activities into the overall institution's performance improvement program,
- Use of Registry data to incorporate nursing policies/procedure changes and/or revisions,
- Any questions regarding overall compliance with PTSF Standards,
- Any additional performance improvement topics and/or questions identified from the Application for Survey or site survey information.

## **Emergency Medicine/Neurosurgeon/Orthopedic Surgeon**

The additional members of the site survey team (Emergency Medicine, Neurosurgeon, Orthopedic Surgeon or Hospital Administrator) will meet with representatives of their specialty to discuss the following:

- All Significant Issue(s) assigned to them,
- Any specific trauma performance improvement activities related to their specialty (why indicators were selected for review/actions taken to resolve clinical and/or system issues/how PI information is communicated to the Trauma Service/use of trended data to demonstrate appropriate changes),
- Any questions regarding overall compliance with PTSF Standards,
- Any additional performance improvement topics and/or questions identified from the Application for Survey or site survey information.

**Hospital Tour (8:45 a.m. - 9:15 a.m.):**

Not all surveyors will be able to tour the entire facility. The purpose of the tour is to acquire an overall sense of the geography of the institution or the distance from one area to another in relation to the flow of the trauma patient through the institution in preparation for the medical record review. Be prepared to provide specific directions to your tour guide.

A major focus of the tour is for you to acquire a sense of how the trauma patient travels from the Emergency Department (admission) to studies (Radiology/CT), to the Operating Room and/or the Intensive Care Unit.

Recommended Tour Route (3 member team)	
Trauma Surgeon Team Leader	Operating Room, Emergency Department, CT
Trauma Surgeon	Emergency Department, Radiology/CT, Intensive Care Unit
Registered Nurse	Medical/Surgical Unit, then work backwards through the patient care flow system
Recommended Tour Route (4 member team)	
Trauma Surgeon Team Leader	Operating Room, Emergency Department, CT
Trauma Surgeon	Emergency Department, Intensive Care Unit
Neurosurgeon, Orthopedic Surgeon or Additional Trauma Surgeon	Intensive Care Unit, Radiology/CT, Emergency Department
Emergency Physician	Emergency Department, Radiology/CT, Helipad
Registered Nurse	Medical/Surgical Unit, then work backwards through the patient care flow system

The tour is most beneficial when you “walk and talk.” Focus your questions on Standards Matrix assignments, Areas for Further Review and Significant Issues. This is an excellent opportunity to talk with staff members in the clinical areas to determine their roles in the trauma program.

Hospital staff members know that you may not have time to stop in every unit or to be introduced to each staff member on the units you visit. Please, feel comfortable to state when it is time to move on to the next area.

Stay with your assigned tour guide. Maintain the time schedule when touring and report to the room designated for medical record review at the designated time. If you run late and it is necessary for Foundation staff to have your tour guide paged, please return immediately.

**Medical Record Orientation** (9:15 a.m. until 9:30 a.m.):

Hospital staff will orient you to the medical record format. The Foundation provides suggestions for this orientation; however, the content of the orientation is the institution's choice. Since the medical record review is a major portion of the site survey, please give the orientation your full attention. Ask questions; do not make assumptions. If electronic medical records are used, additional education may occur the evening prior to survey day. Review of Performance Improvement documentation is also part of this section. Trauma program staff is asked to have at least one resource person per surveyor to answer questions.

**Standards and Medical Record Review** (9:30 a.m. until Noon):

The review of medical records and abstraction of information and data entry into the site survey software occurs during this time. The site survey software is equipped with automatic skips, drop-down menus and downloaded information taken from the PTOS database.

Please be sure to ask questions and seek clarification when reviewing medical records. Hospital staff is always present to ensure that all the information the site surveyor team requires is readily available.

- **NOTE:** (1) During medical record review each trauma surgeon will be given approximately two unexpected survivors/three unexpected deaths for review. (2) Any physician member of the site survey team can request to review unexpected survivors/deaths during the medical record review. (3) All performance improvement documentation related to the review of unexpected outcomes and clinical occurrences that shows problem identification, case review, and status in the PI process, and actions taken, will be provided by the trauma center.

**Lunch** (Noon until 12:30 p.m.):

The survey team will have lunch at the institution in a private room. This will be one of the first opportunities for the survey team to meet in private to discuss the survey day. Lunch will be served; surveyors will have an opportunity to talk among themselves and with Foundation staff and to take a brief break from the survey day. This is a "working lunch" and Foundation staff is prepared to provide guidance for structuring the afternoon. This could include, for example, the request for additional information, medical records, facility interview(s) and Registry reports/information.

**Binder Review** (12:45 p.m. until 1:00 p.m.):

*This session allows the institution to choose three items that the institution feel are important, one of those items should be audit filters/occurrences, and present that information to the site surveyors (One item to each surveyor). This is optional, up to the discretion of each trauma program.*

***Medical Record Review & Review of Performance Improvement Information and referred items from PTSF staff (1:00 p.m. until 4:00 p.m.):***

- **NOTE:** This time will also be used for the surveyor to review standardized queries that the institution must have available on site survey day and can be used for any dialogue regarding performance improvement activities that was not fully explained during the morning review session.

***Survey Team Conference (4 p.m. until 5:30 p.m.):***

This closed meeting is for the survey team to prepare for the leadership meeting. Only site survey team members and Foundation staff will be present.

While this is a good time to exchange information and obtain your team members' impressions of their review, it is not a forum to reach a consensus or "vote." Each surveyor reviews the institution from his or her own specialty/discipline and therefore, impressions may be different.

The survey team conference is for the team to develop questions for the leadership meeting and to determine if any other information is needed in order to complete the surveyor report(s). The team leader will determine the order in which each surveyor will speak during the leadership meeting. If the Significant Issues were presented to the surveyors as a group, the team leader will determine who will lead the discussion related to the Issue.

***Leadership Meeting (5:30 p.m. until 6 p.m.):***

The Leadership Meeting is the final fact finding interview for the surveyors. All surveyors will participate for the purpose of clarifying issues and obtaining additional and final information to complete your site survey report. Major concerns that must be addressed include:

- Conflicting information,
- Lack of information or explanation,
- Areas of concern that require further clarification,
- Issues/information for which you need confirmation,
- Potential areas of non-compliance by the institution.

Foundation staff will begin the meeting with some very brief comments and then turn the meeting over to the Team Leader who will facilitate the discussion. This discussion should be candid.

### **Trauma Surgeon Team Leader Role**

- Primary responsibility is to coordinate discussion related to areas of non-compliance and areas requiring clarification as identified by the team members during the survey team conference.
- Coordinate discussion of issues resulting from the medical record review, such as documentation, response/immediacy of care and quality of care through use of trauma service/program performance improvement criteria.
- Moderate the Leadership Meeting to provide each surveyor with an opportunity to obtain information to complete his/her evaluation of the institution.
- Intercede if either a surveyor or hospital staff member is exceeding the bounds of the validation meeting process.

Each team member should:

- Request further clarification (if necessary) of any areas of non-compliance related to your specialty.
- Explain the significant issue that was assigned to you and how thoroughly the institution showed evidence of resolution.
- Identify strengths of the trauma program. This should match the strengths listed in the summary comments.
- Identify opportunities for improvement of the trauma program. This should mirror the opportunities for improvement listed in the summary comments.

If additional information received at the Leadership Meeting affects your review and response in the software, be sure to make the addition or correction in the software by notifying Foundation staff of the need to access the computerized review program.

- This forum is not meant to be an opportunity for you to share your opinions regarding whether the center should be accredited. The PTSF Board of Directors determines this.
- Refrain from expressing personal opinions regarding Standards compliance, efficacy of the Standard, or the site survey process.

**Adjournment** (6 p.m. or at the conclusion of the Leadership Meeting):

The survey team and Foundation staff will either travel to the next location or return to the previous hotel at which time the surveyors can make changes to the surveyor software if needed.

## Reviewing Significant Issues

A significant issue is an item/issue that the PTSF Board of Directors agreed was a significant deficiency during the institutions most recent site survey. Institutions are required to develop an action plan in response to each significant issue. This action plan should include historical data to further define and determine the cause of the significant issue, interventions or actions that will be taken to improve or eliminate the significant issue, institution-developed timelines for resolution of the significant issue, internal and external benchmarking data (as appropriate) to show improvement and resolution of the significant issue. The significant issue(s) and the action plan are provided in the institutions EAFS.

Performance improvement data **MUST** be available to demonstrate the resolution of significant issues on the day of site survey through an action plan. Each site surveyor should be well-versed regarding each significant issue and action plan(s).

The site surveyor team **MUST** be able to determine that actions specifically designed/implemented by the trauma program and/or institution have resulted in demonstrable positive changes/improvements. However, it is also noted that some significant issues are extremely difficult and may take an extended period of time before resolution is finally achieved. In these situations, demonstration of positive progress toward issue resolution (appropriate modifications/evaluation/utilization of resources to incorporate appropriate change) is acceptable.

Additional helpful hints that have been provided to the trauma centers regarding significant issues include the following:

- Assign a specific individual who is *directly* related to the significant issue and will be responsible for discussing this specific significant issue on the day of the site survey. All of the information regarding activities performed to resolve this significant issue should be available in one binder/notebook/file. The binder/notebook/file should contain an executive summary (one page), which outlines the activities/data/ information/time line that demonstrates that the significant issue has been resolved. All of the supporting data would then be arranged/tabbed/ referenced for easy identification and review by the site surveyor and **all contained in one location**.
- Review all information/supporting data for clarity.
- Practice (conduct a mock site survey performance improvement session) to ensure that your presentation relates the necessary information to the site survey team. A “top 5 list of activities and accomplishments” for each significant issue may be helpful.
- Time the session. You have approximately 45 minutes to discuss the significant issue(s) and you cannot have a doctoral dissertation for each one.
- Be very selective when determining which significant issue(s) will be presented by the trauma program medical director and trauma nurse coordinator. It is impossible to have these two individuals presenting the information/data for all of the significant issues.
- Review the Site Survey Guidelines for more specific information regarding the format and setup of the room where this activity is to occur.

There is a lack of resolution for a significant issue if:

- **NO** activity has occurred,
- **NO** resources have been allotted to effect change,
- **NO** trended data is available,
- **NO** use of registry data,

- **NO** acknowledgment of the significant issue has occurred, and
- **NO** objective evaluation of the significant issue, root cause and activities to eliminate the problem, can be demonstrated.

### **Example of resolution of “Timely response of Neurosurgeons”**

Summary:

A significant issue regarding the timely response by Neurosurgery was identified in the October 1<sup>st</sup> Accreditation report. After appropriate evaluation and root cause analysis, it was determined that the lack of timely neurosurgical response was the result of an unclear policy regarding the physical presence of the attending Neurosurgeon, the failure by Neurosurgery to document their arrival time, and the failure of Neurosurgery to respond in a timely fashion when requested.

The action plan outlines review and revisions to the policy that included specific clinical criteria that required the presence of the attending neurosurgeon, a tiered activation that includes emergent/urgent/ routine consult with specific time requirements for the patient’s timely evaluation, commitment by the Neurosurgeons to support the trauma program, and appropriate directed documentation. Current documentation outlines the level of consult, the time and date the consult was initiated, and the expectation that the attending Neurosurgeon will respond and “sign in” on the trauma flow sheet.

Data elements that could be tracked trended and include in a “data” section might include:

- Was the appropriate level of Neurosurgical consult initiated by the trauma surgeon?
- Was the consult timed and dated by the attending trauma surgeon?
- Did the attending Neurosurgeon respond in a timely fashion?
- Did the attending Neurosurgeon “sign-in” on the trauma flow sheet?
- Did the attending Neurosurgeon provide appropriate clinical care?

Data is collected, trended by the individual provider (attending trauma surgeon and attending neurosurgeon) and the results are reviewed to determine if additional actions are required. Data elements are trended for resolution and re-evaluation at reasonable intervals to assure loop closure.

On the day of the site survey, the trauma center would have the ability to unequivocally state that *every* Neurosurgical consult has been reviewed for appropriateness and timeliness of consult, the attending Neurosurgeon *did* respond in a timely fashion, they did “sign-in” on the trauma flow sheet or in the electronic record, and the neurosurgical clinical care was reviewed for appropriateness.

## Documenting resolution of Significant Issues

Comments entered into the site survey software should include:

- Evidence that the significant issue has been resolved, has improved, or remains an area for improvement. This information is obtained during the:
  - The significant issue review,
  - The medical record review,
  - In queries, meetings, or via other means as appropriate

### **An example of a significant issue comment that would be useful to the PTSF Board of Directors is:**

*“It is the opinion of this surveyor that the issue has been successfully addressed by the hospital, with significant resolution, and with ongoing progress.*

*During the period from October 2005 until the date of the survey, there were 26 trauma laparotomies; eight of these 26 patients had a CT scan prior to laparotomy. Three of the patients who underwent laparotomy were hypotensive prior to surgery. Significantly, however, there were no patients who were hypotensive preoperatively who underwent CT scanning prior to laparotomy.*

*Further, the hospital provided a rather elegant analysis comparing its time from patient arrival to laparotomy with average times from state data. This demonstrated no difference whatsoever, and further, showed no statistically significant relationship between preoperative ED length of stay and outcomes.*

*The hospital developed and implemented a policy whereby nursing staff members of any seniority are empowered (and mandated) to contact the attending trauma surgeon with questions of any variety, regardless of the time of day or night. Chart review demonstrated that this appears to have been successful.*

*The hospital’s performance improvement program has been modified to require a formal review of the resuscitative phase (according to ATLS guidelines) if certain criteria are met. This was reviewed in many medical records and found to be highly effective in allowing the trauma program to gain an understanding of the practice patterns of individual surgeons. Examples were given of surgeon-specific additional educational requirements based upon the results of this analysis. The additional requirements have included a focused review, an additional trauma-specific CME requirement, and the mandate that they teach an additional amount of ATLS courses locally.*

*Additionally, chart review at the time of this focused review identified only a very small number of patients thought to have undergone under triage or under-resuscitation. Ventilatory management in the resuscitative phase and the critical care phase seemed quite appropriate, and there were no noted examples of resident physicians acting without appropriate attending physician supervision.*

*All four surveyors felt that an appropriately consistent approach toward the management of the critically injured patients, particularly during the resuscitative phase, has been undertaken during the period of time studied at this visit.”*

## Medical Record Selection Criteria

### Purpose:

To provide an unbiased random sample of patient records for review by site surveyors in conjunction with the accreditation process. Foundation staff will ensure you review an adequate mix of all types of cases. If medical record reviews are conducted and problematic areas are identified, you may request charts from Foundation staff based on injury type.

### Procedure:

A computer-generated list of cases will be selected from the Pennsylvania Trauma Outcome Study (PTOS) database. All cases will be selected from January 1 of the previous year to the date the list is generated\*.

Records will be selected according to the type of Accreditation Survey:

- Accredited Trauma Center with Three-Year Accreditation: January 1<sup>st</sup> (previous year) through date of survey
- Trauma Center with Provisional Accreditation: October 1<sup>st</sup> (previous year) through date of survey
- Trauma Center with One-Year Accreditation: October 1<sup>st</sup> (previous year) through date of survey with focus on January 1<sup>st</sup> through date of survey (within current year)
- New Applicant: January 1<sup>st</sup> (current year) through date of survey

The cases selected must meet the following criteria:

- ISS > 13, RTS < 7.56
- All ages, including < 14; > 70 < 85
- Deaths, Transfers into or out of the institution
- Burns
- Occurrences (complications) with special attention given to:
  - General Surgery: 1) Coagulopathy, 2) Acute Respiratory Distress Syndrome (ARDS), 3) Deep Vein Thrombosis (DVT), 4) Wound Infection (extremity wounds), 5) Wound Infection (penetrating)
  - Neurosurgery: 1) Meningitis, 2) Seizures, 3) Cerebral Infarction/Stroke
  - Orthopedics: 1) Compartment Syndrome, 2) Decubitus
- ICU length-of-stay, selecting either ICU length-of-stay > 2 times the institutional average or > 2 times the PTOS average, whichever is greater
- TRISS unexpected death or TRISS unexpected survivor

Approximately 20 cases per surveyor will be selected using the aforementioned criteria. Staff will ensure an adequate distribution of body system/organ injuries:

- |                    |                           |
|--------------------|---------------------------|
| ▪ Penetrating      | ▪ Chest (including aorta) |
| ▪ Head             | ▪ Pelvic                  |
| ▪ Neck Spinal cord | ▪ Major extremity         |

And a wide range of demographics and dispositions:

- |                                 |                      |
|---------------------------------|----------------------|
| ▪ Discharge status (live/die)   | ▪ Length-of-stay     |
| ▪ Discharge destination         | ▪ Admission services |
| ▪ Post-ED admission destination |                      |

## Medical Record Review

### Purpose:

The Board of Directors considers quality clinical care to be a fundamental component of an institution's compliance with the Standards and critical to maintain trauma center accreditation. The medical record review is designed to demonstrate, through the documentation of clinical management and outcome, compliance with the Standards for Trauma Center Accreditation. It is necessary to review an adequate number of medical records to determine compliance with the Standards.

Optimally, each surveyor will review a minimum of ten records. In order to review an adequate number of charts, you should average no more than 30 minutes per medical record. Your familiarity with the site survey software used during survey will assist in achieving this goal.

### Objectives:

To review the medical record in terms of:

- Prompt availability of clinicians and services,
- Demonstration of clinical services that are reflecting state-of-the-art trauma care,
- Ability to provide clinical services and properly credentialed and experienced trauma personnel,
- Outcome of clinical management,
- Adequate, ongoing peer review based on the institution's own measurable audit filters and the PTSF Standard XXXIII - Trauma Performance Improvement Programs,
- Demonstrated performance improvement processes and outcome for those clinical and system issues that affect patient care.

It is increasingly common for many hospitals to use electronic medical records instead of paper. If this is the case, a hospital staff member will be assigned to each surveyor to assist in document retrieval if necessary.

## Site Surveyor Medical Record Documentation

**The rating scale for the medical record review consists of:**

1. Acceptable
2. Acceptable with reservations
3. Unacceptable

Comments are *required* for all responses noted “acceptable with reservations” and “unacceptable.” However, do not limit comments to issues with these two classification results. Comments are strongly encouraged. It is necessary to provide objective comments that are clear, concise, thorough—and based on facts identified in the medical records and hospital documents.

The Board of Directors relies on the site surveyors’ reports to provide accurate, descriptive information regarding the applicant hospital and the documents reviewed. Since they (The Board of Directors) do not have the actual documents and medical records to refer to during their meeting, please be sure your comments provide a complete, understandable and accurate description of the situation, especially when reviewing trauma related deaths.

**Inconsistencies between your summary comments and the medical record review are very problematic when the Board is making an accreditation decision.**

Because the Accreditation Reports are written using the site surveyors’ reports and comments from the Board of Directors, it is extremely important for your comments to be clear and provide sufficient detail to be accurately understood.

- If you make an error or wish to change a response, please make the changes directly in the site survey software.
- Do not use abbreviations that are not common to your field of practice nationally.
- Document times in military time.
- Document discussions with the trauma program staff with regards to substandard clinical practices for which loop closure is either inappropriate or not clearly documented in performance Improvement records
- Because all information presented to the Board of Directors needs to be blinded, please use titles rather than names as appropriate.

<u><b>Rather than:</b></u>	<u><b>Use:</b></u>
Dr. Smith.....	“Trauma medical director” or “TMD”
Lisa or Frank.....	“Trauma program manager” or “TPM”
Life Lion .....	“Helicopter program”
Philadelphia .....	“This area or this location”

- Foundation staff will review ALL site survey documentation and will ask the site surveyor to clarify any unclear documentation.

## Performance Improvement Review

Review the trauma program and hospital performance improvement process as it relates to your specialty and each medical record you review. Comments must be documented in the performance improvement summary comments section of the site survey software and during the medical record review.

### **Objective:**

To evaluate the institution's trauma program performance improvement, its link to the hospital-wide performance improvement program, and its effectiveness from problem identification through re-evaluation.

### **Process:**

- Please refer to Standard XXXIII—Performance Improvement Programs that outlines the requirements for performance improvement, as well as the hospital's Application for Survey. Based on this information, review the performance improvement documentation available the day of the site survey and complete the performance improvement review forms appropriate to your specialty.
- Individual medical record performance improvement documentation will be provided for review.
- The hospital staff members will explain their retrieval method if performance improvement documentation is not provided in an accompanying folder.
- All trauma centers are required to use POPIMS (Pennsylvania Outcome Performance Improvement Measurement System). This software program serves as a repository of performance improvement information and allows selected demographic and clinical information to be automatically downloaded from the trauma registry program (Collector) into POPIMS.

### **Additional features regarding POPIMS include:**

- The ability to track and trend specific data elements over time.
- The ability for an Institution to define specific "user defined elements."
- Serves as the hospital's central repository for all performance improvement activities specific to a patient record (i.e. trauma related committees and/or conferences, Morbidity and Mortality Committee, "grading" of clinical and system issues, mechanism to track loop closure and provider specific information).

## PTSF Preventability Grading System

**During the medical record review, only physicians will review deaths; the site survey software has been configured this way:**

Conducting a peer review related process that objectively determines preventability regarding clinical care and trauma system issues is critical. This requires a systematic approach to the review of clinical care including active participation by peers. It is necessary to have frank and open discussions directed toward education and improving patient clinical care and trauma systems.

The PTSF Ad Hoc Committee to Develop Site Survey Outcome Measurements modified the definitions taken from the handbook, *Trauma Performance Improvement - A How to Handbook*, November 9, 1999, ASCOT.

### **Preventable Mortality**

- Anatomic injury or combination of injuries considered survivable.
- $P(s) > 0.5$  by TRISS methodology.
- Standard protocols not followed with unfavorable consequence.
- Inappropriate provider care with unfavorable consequences.

### **Potentially Preventable Mortality**

- Anatomic injury or combination of injuries considered severe but survivable under optimal conditions.
- $P(s) 0.25 - 0.5$  by TRISS methodology.
- Standard protocols not followed, possibly resulting in unfavorable consequence.
- Provider related care considered sub-optimal, possibly resulting in unfavorable consequence.

### **Non-Preventable Mortality**

- Anatomic injury or combination of injuries considered non-survivable with optimal care.
- $P(s) < 0.25$  by TRISS methodology.
- Standard protocols followed or if not followed, did not result in unfavorable consequence.
- Provider related care appropriate or if sub-optimal, did not result in unfavorable consequence.

## Documenting Summary Comments

The summary comments should be a summary of your findings from the entire day. Comments should be based on information from opening conference, physician and nurse meetings, hospital tour, medical record review, queries, and discussions with the institution's trauma team.

Comments are split into three areas:

1. Overall Summary of Medical Record Review,
2. Overall Summary of the Performance Improvement Program,
3. Overall Strengths and Areas for Improvement.

The comments entered into the site survey software should include all of the following and should be supported by the medical record review when applicable:

1. Overall Summary of Medical Record Review
  - Commitment by the institution's Board of Directors, administration, medical staff, and nursing to treat trauma patients and have adequate resources to do so.
  - Capacity to care for adult and pediatric major single system and multi-system trauma including adequate surgical and ICU capabilities.
  - Evidence of meeting trauma surgeon volumes as outlined in Standard II.G.
  - Attending Trauma Surgeon participation in major therapeutic decisions and presence in the ED for highest-level activations.
  - Attending Sub-specialist participation in decisions related to specialty and appropriateness of response time when consulted must include: Neurosurgery, Orthopedic Surgery, Emergency Medicine, Anesthesia, Radiology, and "other," as necessary.
  - Use of clinical management guidelines.
  - Resident Supervision (if applicable).
  - Use of mid-level providers (if applicable).
2. Overall Summary of the Performance Improvement Program
  - Effectiveness of concurrent and retrospective review of trauma patients.
  - Integration into the institutions overall performance improvement program to include reports to the governing body.
  - Institution resources to support the trauma performance improvement program.
  - Use of specific pediatric audit filters including one for early identification of child abuse.
  - Trauma Medical director role in performance improvement forums.
  - Monitoring of compliance with patient management guidelines.
  - Education provided based on findings from the performance improvement process.
  - Discussion on the appropriateness of the following six areas of performance improvement:
    - Problem Identification
    - Problem Discussion
      - Problem Analysis
      - Preventability
      - Action Plan
      - Implementation

- Loop Closure/Re-evaluation
- The use of POPIMS as a PI documentation tool.
- Use of examples of peer review and system issues identified or not identified by the institution found during medical record review.

### 3. Overall Strengths and Opportunities for Improvement

- Include all of the strengths and areas for improvement identified from opening conference, physician and nurse meetings, hospital tour, medical record review, queries, and discussions with the institution's trauma team. These strengths and opportunities should be based on the Standards for Trauma Center Accreditation.

## Process to Access the Site Survey Software

Ample time will be provided the evening prior to the site survey (during the orientation session) to familiarize yourself with this software. If you have any questions/comments, do not hesitate to contact a Foundation staff member.

## Site Survey Software User Documentation

The following written materials will acquaint you with the site survey software medical record review process that you will utilize during the site survey. You will receive ample time to familiarize yourself with the software at the evening orientation session, prior to site survey.

### Site Survey Software Content

It is strongly recommended that you examine this document and become familiar with the screens, questions and selected responses *prior* to your arrival in Pennsylvania. Time is scheduled during the site survey orientation to review the process and answer any questions that you may have. The laptop computers, provided by the Foundation, will be set up and available for your use during the orientation.

### PTOS Registry Information

When a data field and/or text are highlighted in **blue**, this indicates the information has been entered by the hospital and “downloaded” via the PTOS Registry. This data cannot be changed or altered and is for informational purposes only. If you find information during your medical record review that contradicts downloaded PTOS Registry information, please use the “Additional Comment” field related to that specific phase of care.

The first several screens contain downloaded PTOS information, such as demographic information (age/cause of injury/emergency department admission date/GCS on admission/total ICU days/ discharge destination), complications, operative and non-operative procedures (coding) performed during resuscitation, and the final anatomical diagnosis(es). As you progress into the medical record review, the number of “downloaded PTOS Registry” elements becomes fewer and fewer.

- **NOTE:** The first site survey software screen that requires data entry relates to the pre-hospital phase (for example, “Is the trip sheet located in the medical record?”).

### Response Selections

- Yes/No
- Other
- Specify

The medical record review questions are phrased in a fashion to obtain a “Yes/No, Other or Specify” response. In a majority of the responses, if “No” is selected, a drop down menu will

appear that lists the reasons for the “No” response, as well as a selection termed, “Other.” You then select the appropriate response(s) or type in your response under “Other”.

- Site Survey Software was structured to incorporate a majority of the appropriate responses within the drop down menus and have surveyors place their free text/additional comments on the “Quality of Care, Immediacy of Care and Documentation of Care—Additional Comment” screens. (Quality of Care, Immediacy of Care, Documentation of Care and Additional Comment screens will be explained in detail).
- There are selected questions in which the “Yes” response will trigger the drop down menu. Again, the process to select the appropriate response or type in an “Other” response remains the same.
- Limited clinical questions indicate “Specify” for areas of concern and non-compliance. For example, if the appropriate laboratory tests were not ordered, the answer requires more specific information. The desired response is to indicate which laboratory test(s) were not ordered. The surveyor would then type in the specific lab test (for example - CBC, PT/PTT).
- The available space to type in the “other” and “specific” information is limited (approximately 30 characters). Please use answers that are succinct. The questions have been formatted to obtain short, specific answers.

### Unable to Locate in Medical Record

In selected areas, such as pre-hospital (trip sheets in the medical record), radiology and CT (documentation that the patient was monitored appropriately), discharge planning, rehabilitation, and performance improvement, a response selection is termed “Unable to Locate in Medical Record.” All of the questions in which this response selection is listed relate strictly to documentation issues. This response was created in an effort to minimize the amount of surveyor time for each medical record review (**have the hospital staff locate the information in the medical record**) and decrease the number of purely documentation issues within the medical record review.

The maximum number of questions that contain this response is ten per medical record although this may vary depending on the surveyor specialty and the phases of care the trauma patient experiences.

If “Unable to Locate in Medical Record” is a chosen response, upon completion of the medical record review, the information will be downloaded to the Foundation staff computer. A report will be generated which lists the questions where “Unable to Locate in Medical Record” was selected. This list will be given to the hospital staff that will attempt to locate the information in the medical record. Hospital staff will “flag” the medical record in the appropriate location and the information will be presented (by Foundation staff) to the surveyor. The surveyor then can re-open the medical record and select the appropriate response(s) for those specific questions. If you have any questions regarding this component of the medical record review, please discuss this with Foundation staff during the site survey orientation.

## Rating the Phases of Care

Each phase of care (pre-hospital, resuscitation, radiology and computerized tomography, perioperative, neurosurgical, orthopedic, critical care, post-resuscitation, discharge planning, rehabilitation, and performance improvement) contains a rating and additional comment section. A rating for that specific phase of care is required when the trauma patient experiences that specific phase of care.

- **NOTE: It is highly unlikely that every trauma patient will enter each phase of care.**

The rating scale is:

1. **Acceptable**—there is no question that the clinical management was appropriate,
2. **Acceptable with Reservations**—there is marginally acceptable clinical management or interventions,
3. **Unacceptable**—there is no question that the clinical management deviates from the established standards of appropriate clinical care.

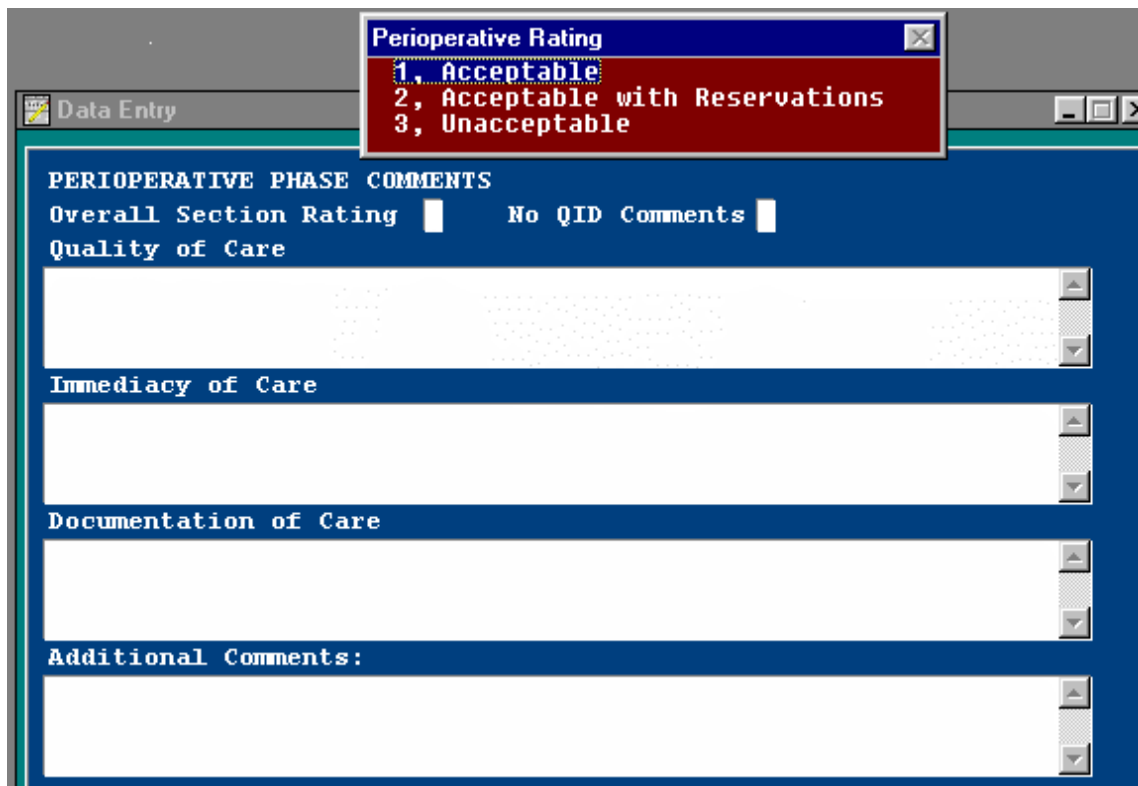
If the phase of care is graded as “1—Acceptable,” the surveyor can select “No Q/I/D Comments” and this area will be skipped; **however, positive comments or comments that will allow the Board some insight into care are encouraged.** The next section that appears is the “Additional Comments” field. Any time a phase of care or the summary assessment is rated as a “2—Acceptable with Reservations” or “3 –Unacceptable,” comments are required.

- **NOTE: Comments must provide specific information related to that phase of care. The goal is to provide quality information to the Board of Directors to assist in the accreditation process.**

## Q/I/D Comments

Each phase of care contains a rating section that is divided into four areas. This is referred to as the “Q/I/D (three areas) - Additional Comment (one area)” screen. Your comments, related to ratings of 2 and 3, must be placed within three distinct areas. They include:

- **Quality of Care**—the ability to provide quality trauma care (conforming to institutional, national, and recognized trauma care standards) BASED on the patients clinical status
- **Immediacy of Care**—the ability to provide appropriate TIMELY clinical trauma care (such as evaluations, tests, procedures) BASED on the patients clinical status.
- **Documentation of Care**—the ability to demonstrate an accurate, written medical record and performance improvement process that reflects clinical findings and overall trauma patient care.
- **Additional Comments**—is a field provided for any other pertinent information that the surveyor deems important to this specific phase of care and/or medical record.



When any phase of care or summary assessment is rated as a “2 or 3” the surveyor should select the appropriate field(s) (Quality, Immediacy, or Documentation), and enter comments.

- **NOTE: SITE SURVEY SOFTWARE has been structured and the Foundation STRONGLY encourages all surveyors to place positive comments, specific details that give the Board insight into care, and written text in the “Q/I/D - Additional Comment” screens.**

### Automatic Skips

The Site Survey Software has been programmed with automatic skips. For example, if the trauma patient goes from the Emergency Department to the Intensive Care Unit (post Emergency Department destination), the perioperative section of Site Survey Software will be “skipped.” If neurosurgery is NOT involved in the care of the trauma patient, the section related to neurosurgical trauma care will be “skipped.”

Each specialty has been programmed to skip portions of Site Survey Software. The auto skips occur in response to the individual trauma patient/phases of care, and your response to questions.

### Medical Record Review

The front of each Patient Performance Improvement record will have a cover sheet attached. This cover sheet contains basic information related to the patient, (for example, cause and type

of injury, dates/times), and general demographic information. This information should be utilized as a screening tool in order to ensure that you review a wide variety of patient types and levels of injury. If you do not want to review that specific medical record, just put it down and pick up the next medical record. There will always be several medical records from which you can select.

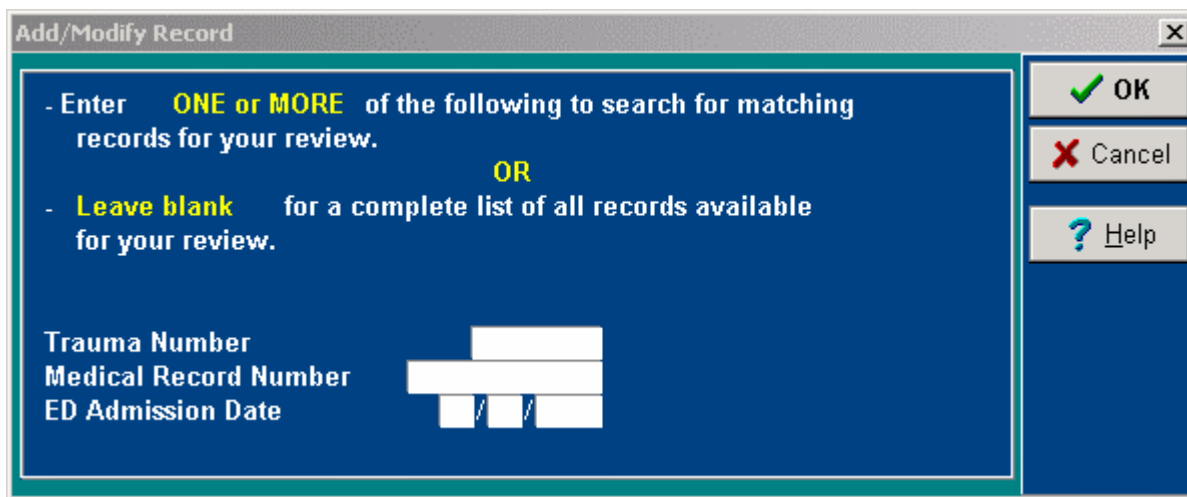
**NOTE:**

- If you review a medical record and determine that another surveyor should review the same record, discuss this with Foundation staff. A process to incorporate a second review of that medical record has been developed.
- If you wish to review a specific type of medical record, (for example, type of injury - spinal cord injuries/penetrating injuries or patients that go from the Emergency Department to the Operating Room), discuss this with Foundation staff. A process to identify specific medical records that the surveyor wishes to review has been developed.

Once you have selected a medical record, the following procedure will occur.

**SELECTING A RECORD**

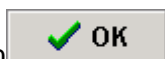
The following is the first screen that you will view; you will have two options:

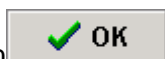



- **NOTE:** The example screens displayed in this orientation manual may appear slightly different from the actual screens included in the tutorial.


**Option 1:** Enter ONE of the following to obtain a specific medical record (The most frequently utilized and recommended option):

- Trauma Number, or
- Medical Record Number



Click on . The medical record with the matching trauma number or medical record number will be displayed.

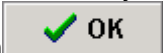
1. Click on  and that specific medical record will be displayed.  
This is the most frequently utilized process to select a medical record for all surveyors.

**Option 2:** Click on  and a list of all records in the database will be displayed.

However, you can also have two other choices:

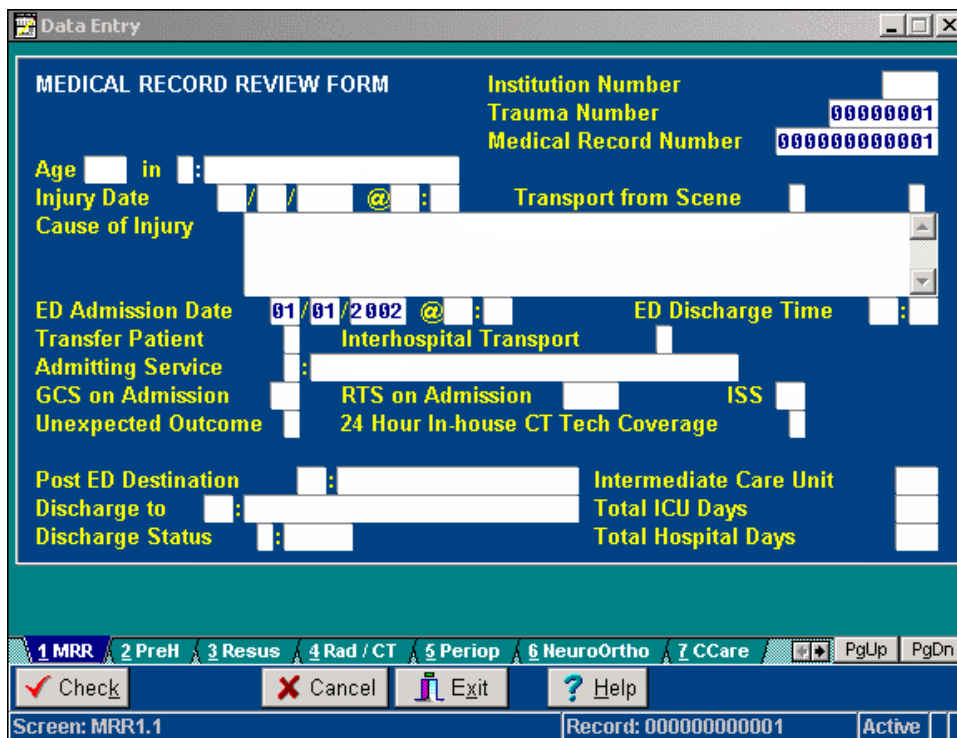
**Option 1: Add a New Record to the Database**  
This enables Foundation staff to enter data regarding medical records that have not been entered into the PTOS registry on the day of site survey. **Do not select this option.** Foundation Staff will **ONLY** use this option.

**Option 2:** Return to Selection Criteria Screen

1. Use the arrow keys to highlight this option.
2. Click on . You will be returned to the initial screen that requests trauma number or medical record identification criteria.

**DATA ENTRY SCREENS**

After selecting the desired trauma number or medical record number and clicking “OK,” the first screen appears and looks similar to this:



Each data entry screen contains questions and/or the names of specific data elements that have been determined to be necessary for the medical record review. Information at the bottom of every screen includes:

- Screen Number, (Screen MRR1.1, GS3.5, OS5.2, NS6.2, EM7.1, RN8.5)
- Medical Record Number
- Record Status, (Active or Closed)
  - Active - all questions and data fields have not been entered or checks for data quality have not been passed.
  - Closed - all questions and data fields have been entered and data quality checks have been passed. A record must be closed before you can exit to select another record.
- || - No new data have been entered for this record during this session.
- |\*| - The asterisk indicates new data has been entered for this record during this session.

### **MOVING THROUGH THE REVIEW SCREENS**



The blinking cursor is positioned on the current field. To move the cursor to the next field or question, you can press “Enter” or use the “right arrow key.” If you want to move to the next page you can select the “Page Down” key. When a field is completely filled, the cursor automatically moves to the next field/question. EXCEPTION: Text Fields—when you are in any text field the “right arrow” key will move you to the next field/question. If you use “Enter,” this will scroll down through the text field until you reach the end of the text field.

You are not required to enter data in the same order as the questions appear on the screens. Several keys are useful in moving through the screens.

To move the cursor to an adjacent field:

- Use the Right and Left Arrow Keys or
- Press Enter

To move from screen to screen:

- Press the Page Up key or click on 
- Press the Page Down key or click on 

To move from one section to another:

- Click on the appropriate section tab



The first screen associated with that PHASE OF CARE would be displayed.

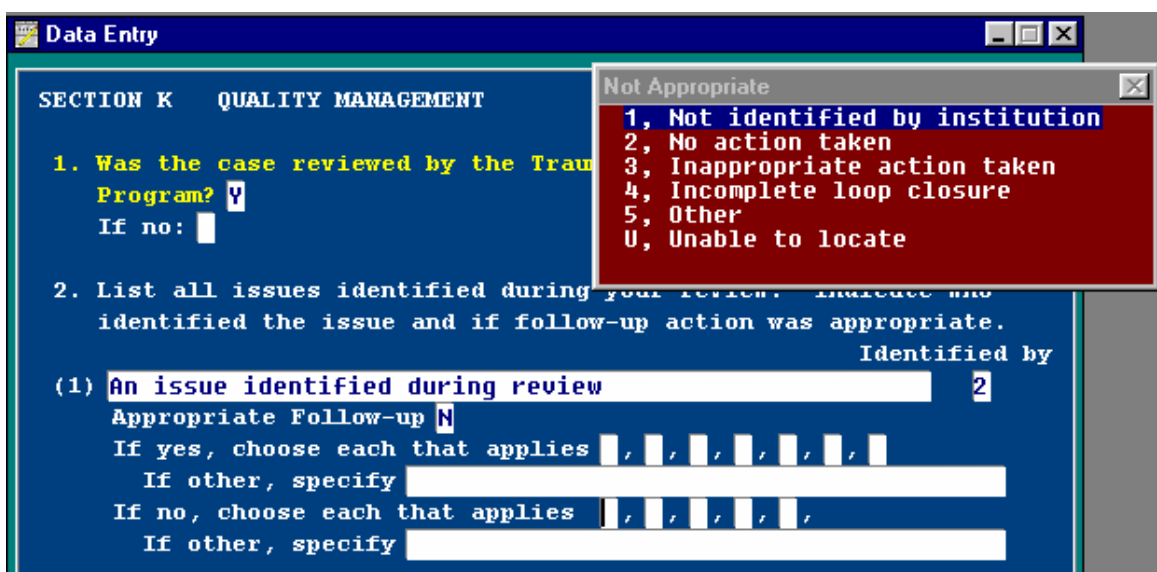
**NOTE:** The section tabs now contains the “text” which corresponds to that section/phase of care for the medical record review. For example, *MMR* = medical record review (basic demographic and Registry information, *PreH* = pre-hospital, *Resus* = resuscitation phase of care, *Rad/CT* = radiology and computerized tomography phase of care, *Neuro/Ortho* = neurosurgery and orthopedic phase of care, *PI* = performance improvement phase of care.

Depending on surveyor specialty, the number of questions and areas for review will differ. The general surgeons and the registered nurse have the most questions/data fields and the emergency medicine physician has the fewest number of questions/data fields.

**POP-UP MENUS**

Pop-up menus showing selected responses and options will be displayed for each question. To select a response you can use your mouse and “double click” on the appropriate selection or “single click” and press “Enter.” You can also type the number for the corresponding choice directly into the field.

The following example of a pop-up menu is related to question #2, (1) “Appropriate Follow-up.” The surveyor responded “No,” and the following drop down menu appeared:



To access a pop-up menu: Press “Alt-M” or click on any item in the menu

To move up and down within a popup menu: Use the “up and down” arrow keys

To exit a pop-up menu: Press “Esc.” (NOTE: This is the only time you should use the “Esc” (Escape) key.)

**COMPLETING THE REVIEW/DATA ENTRY**

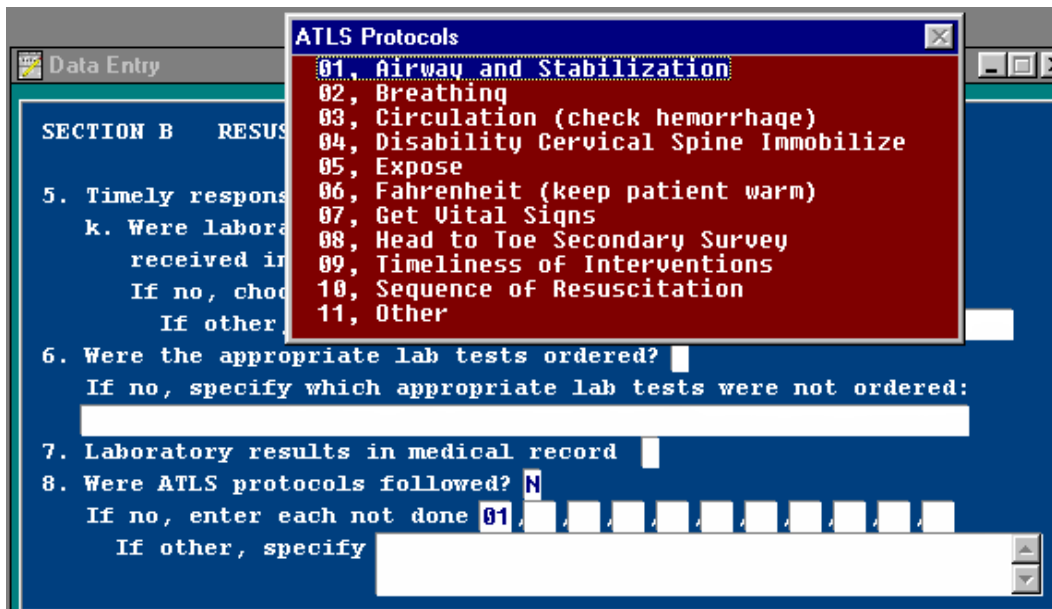
**NOTE: Do not press “ESC” during data entry, EXCEPT when using pop-up menus as described in the previous section.**

***Answering the questions:***

- Select your response in the corresponding field. “Yes / No,” or
- Select your response from the pop-up menu:

1. Highlight your response using the arrow keys
  2. Press “Enter” or “Double Click” your menu choice with the mouse.
  3. Type in your response. .
- If you select OTHER or a selection has SPECIFY as a response, the space available for your response is limited. Therefore, please be brief and exact when entering your response

The following example of a pop-up menu is related to question #8 “Were ATLS protocols followed?” The surveyor responded “No” and the following drop down menu appeared:



The computer is programmed to move you through the review, skipping questions if they are not applicable based on your previous responses. For example, if the patient died, a majority of the screens would be skipped or if the patient did NOT go to the operating room, the perioperative section would be skipped.

### ***Entering Comments***

When entering comments in any memo and/or text field, clear and concise information is required in order for the Board of Directors to understand any issue(s) that you have identified. It is essential that all of your comments are consistent and accurately describe the ability to provide appropriate trauma clinical care, compliance with Standards, and all processes related to the trauma program.

### ***Revising your response***

To revise your response to a question in a data entry field, or in a comment field:

1. Position the cursor on the appropriate field.
2. Highlight the response/words you wish to delete, and press the “Delete” key, or use the “Backspace” key to delete your response.
3. Type your new response.

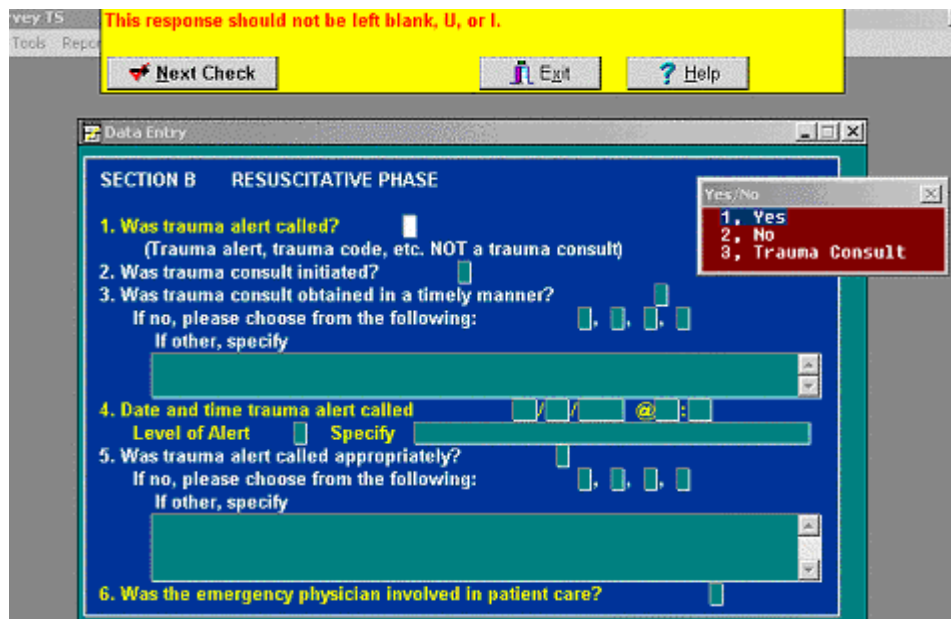
## PREPARING TO CLOSE A RECORD

When you have responded to all questions and entered your comments, enter the "Check Mode" to verify the completeness of your responses:

To invoke the check mode: Click on 


A "check window" will be displayed at the top of the screen. The screen will include a message describing the "missing" data entry issue.

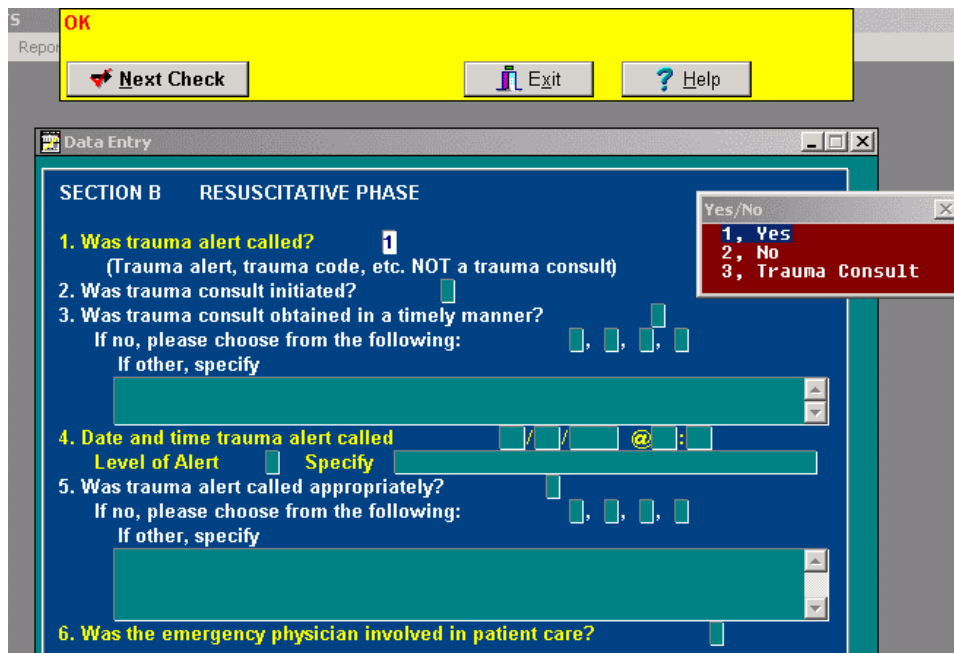
Example: A response was not entered for question #1, "Was Trauma Alert Called?"





If there is a discrepancy between two or more responses, the check window will explain the discrepancy. You will only be able to move among the fields involved in the discrepancy; these fields may be on different screens. The fields not involved in the current check will be black during this check process. Only highlighted (white fields) can be altered during the check process.

**To move among the fields involved in the current check:**

Use the right/left arrow keys . As corrections are made, the error message in the window will change to "OK."



**To proceed to the next check:**

Click on  or press "Alt-N." You may proceed to the next check even if a correction has not been made. Continue to use  (or Alt-N) to cycle through all outstanding checks.

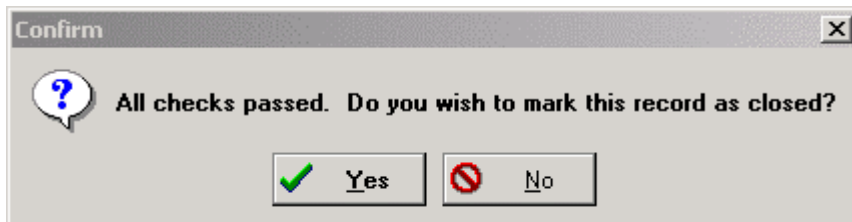
**To exit the check mode:**

Click on  or press Alt-X.

**NOTE:** If the clinical information in the medical record or the selected questions does not contain an appropriate response and you cannot close out the medical record, contact Foundation staff. There is a mechanism that staff can initiate to bypass/validate that specific question and continue the "auto check" phase.

## CLOSING A RECORD

You may close a record when all checks have passed or validated. A record may be closed only when all data for that record has been entered and all checks have passed. The program will automatically ask you if you would like to close the record.



If you wish to close the record click “Yes” or press “Y.” At this point, the information you have entered into SITE SURVEY SOFTWARE is saved. If you do not mark the record as closed, all of the information entered into that specific medical record would **not be saved**.

**NOTE:** Closing a record does not preclude you from making changes at a later time. However, the revised record must again pass all checks before it can be closed again.

### **Areas for Further Review/Significant Issues/Summary Comments**

The required responses related to the “Areas for Further Review,” “Significant Issues”, “Queries” and “Summary Comments” would be entered into the lap top computers. These areas must be completed prior to leaving the facility.

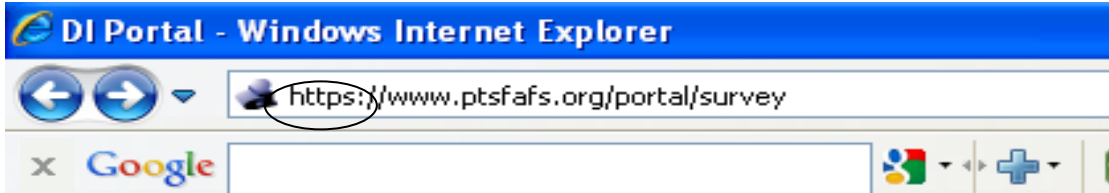
All three of these topics will contain “free text” areas within the Site Survey Software. (The specific process to locate these areas within Site Survey Software will be discussed during the site survey orientation process.)

### **The Screens**

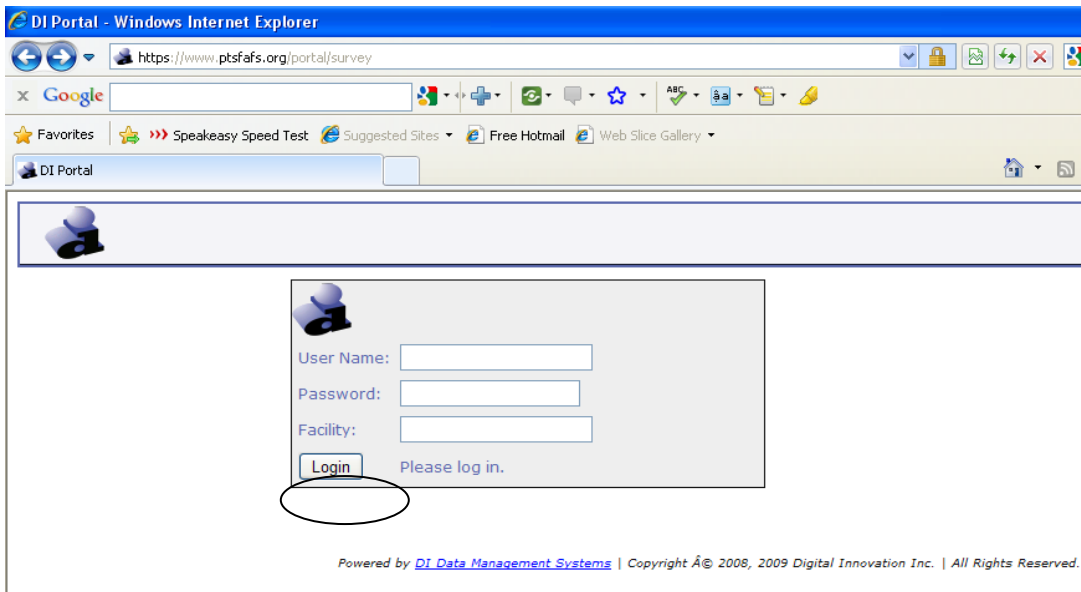
Please review the Site Survey Software computer program to become familiar with the entire process. **It is extremely important that you understand the processes related to Site Survey Software.** This portion of the site survey consumes a majority of the time and energy. Please be prepared to discuss any problems and/or issues during the site survey orientation period. Directions to load the SITE SURVEY software have been provided. If you have any questions, please contact Foundation Staff at (717) 697-5512, or Digital Innovation Staff (Glendene Strickland) at (410) 838-4034.

### Process to Access the Electronic Application for Survey

1. Go to <https://www.ptsfafs.org/portal/survey>. Be sure there is an “s” after the “http”.

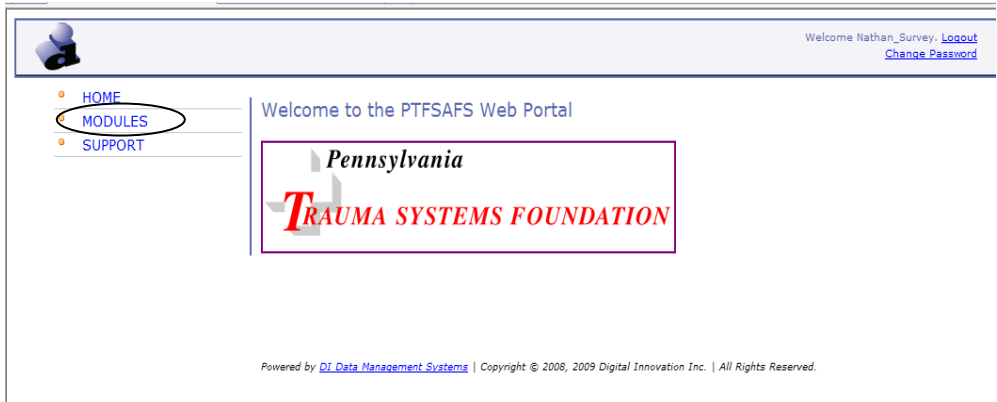


2. On the portal screen enter your Username, Password and Facility ID. All of these will be provided to you by the Foundation. Your Facility ID should match the facility ID of the facility you are surveying.

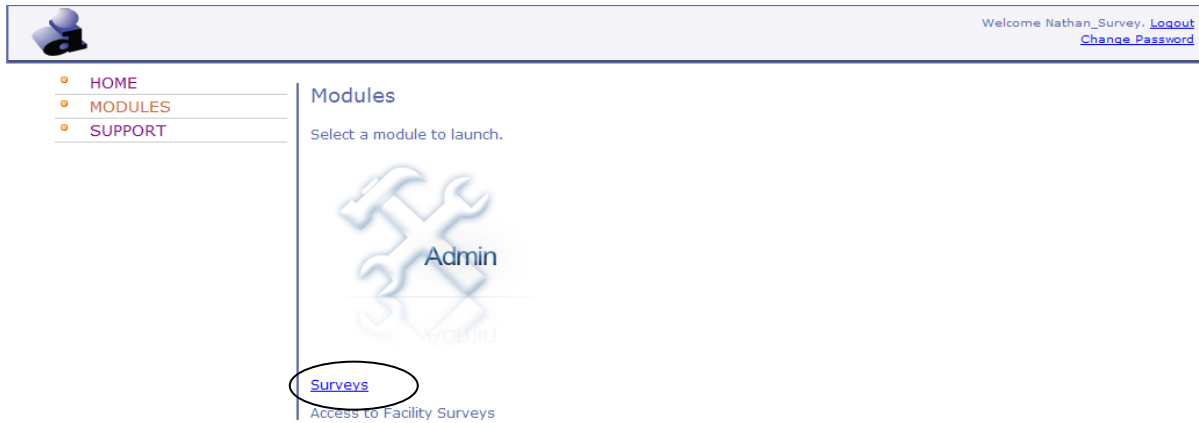


3. Click on the Login button

4. Click on the MODULES button



5. Click on the Surveys button



6. The next screen that will display is the **Record Manager**. The Record Manager is where the user can select the Standard they will review. To select a record, double left click on the Standard. There are several buttons on the right of the screen. The Change Status button is used by PTSF staff to signal to the surveyor that a standard needs further clarification on survey day. Options for selection are:

- **Pending:** This signals the trauma center that PTSF staff had a question regarding their answer that needs clarification. Details can be found in the Master Form.
- **Awaiting\_Correction:** This is an alert to the surveyor that a Standard was not sufficiently clarified by the Trauma Center. Details of the issue can be found in the Master Form.
- **Accepted:** No further clarifications from the trauma center are necessary


Note: PTSF staff will review the EAFS in its entirety and submit any questions to the trauma center. The trauma center will have 2 weeks to clarify the questions. After the clarification period staff will review the answers one more time prior to allowing access of the record to the site survey team.

Double click on the standard you would like to view.

The screenshot shows a web application interface titled "Facility Survey" with a user name "Nathan:1234" and a "Refresh" button. Below the header is a search bar and an "Export CSV" button. The main content is a table with the following columns: Facility Id, Standard Name, Standard Description, Completion Status, Review Status, and Last Modified Date. The table contains 18 rows of data, with the 13th row (Standard 13\_v1) highlighted in blue. On the right side of the table, there are several buttons: "Next", "Refresh", "Review", and "Change Status".

Facility Id	Standard Name	Standard Description	Completion Status	Review Status	Last Modified Date
0204	Facility Information_v1	Facility Information	Completed	Pending	2010-02-05 14:15:44
0204	Standard 1_v1	Commitment	Completed	Pending	2010-02-08 09:43:32
0204	Standard 2_v1	Capacity and Ability	Completed	Pending	2010-02-08 09:53:49
0204	Standard 3_v1	Helipad	Completed	Pending	2010-02-05 15:29:25
0204	Standard 4_v1	General surgery residency pr	Completed	Pending	2010-02-05 15:31:40
0204	Standard 5_v1	Trauma program medical dir	Completed	Pending	2010-02-05 15:34:36
0204	Standard 7_v1	Physician Assistants	Completed	Pending	2010-02-05 15:37:40
0204	Standard 8_v1	Trauma Program Coordinato	Completed	Pending	2010-02-05 12:55:56
0204	Standard 9_v1	Nursing services	Completed	Pending	2010-02-05 12:51:13
0204	Standard 10_v1	Nursing credentials, certificat	Completed	Pending	2010-02-05 12:47:02
0204	Standard 11_v1	Certified Registered Nurse Pr	Completed	Pending	2010-02-05 12:42:16
0204	Standard 12_v1	Post discharge follow-up	Completed	Pending	2010-02-05 12:38:34
0204	Standard 13_v1	Trauma prevention program:	Completed	Pending	2010-02-05 12:36:15
0204	Standard 14_v1	Emergency medical services	Completed	Pending	2010-02-05 12:33:37
0204	Standard 15_v1	Trauma Registry	Completed	Pending	2010-02-05 12:28:45
0204	Standard 16_v1	Organ and tissue donation	Completed	Pending	2010-02-05 12:21:28
0204	Standard 17_v1	Trauma program	Completed	Pending	2010-02-08 07:17:26
0204	Standard 18_v1	Surgical specialist availability	Completed	Pending	2010-02-08 07:24:36

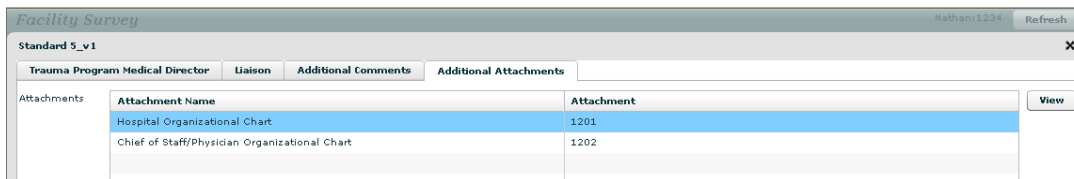
### Process to Access Attachments in the EAFS

Each standard may have multiple attachments that you should review. There are two ways of accessing these attachments in order to review them. First, some questions will have a “View”  button next to them noting that there is a required attached document for that question. Clicking on that “View” button will result in another box opening and asking you whether you want to open it or save it. Clicking on open will bring the document or image up on your screen.

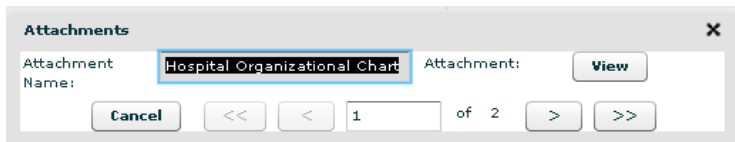
Second, each element will have an “Additional Attachments” tab.



Clicking on this tab will bring up another page with a list of attachment titles associated with this standard.



Double clicking on an attachment line will bring up an “Attachments” box from which you can then click on the “View” button.



Clicking on that “View” button will result in another box opening and asking you whether you want to open it or save it. Clicking on open will bring the document or image up on your screen.

### Process to Print Standards and/or Attachments in the EAFS

It is not possible to print the entire application as one document from the EAFS. However, printing of attachments and standards individually or together is possible.

#### Printing the Standard Only

1. Double click on the standard you would like to print to open it.

Facility Id	Standard Name	Standard Description	Completion Status	Review Status	Last Modified Date
0204	Standard 2_v1	Capacity and Ability	Active	Pending	2010-01-21 15:20:18.19300
0204	Standard 3_v1	Helipad	Active	Pending	2010-02-05 16:14:28.57100
0204	Standard 4_v1	General surgery residency pr	New	Pending	2009-09-24 17:10:21.85300

2. Once in the standard go to the bottom of the screen and click “Print”.

Standard 2\_v1

Guidelines and Protocols

1. Attach copies of the formal written protocols with neighboring trauma centers to accept patients when diversion is necessary.

Facility Name	Formal Protocol

2. Attach copies of the agreements with EMS agencies to transfer unstable trauma patients to a higher-level trauma center.

EMS Agency	Agreement

3. Attach a copy of the policy for mobilization of staff to care for simultaneously arriving trauma patients prior to activation of the facility Disaster Plan.

4. Attach copies of the established guidelines for transfer of severely injured adults and children to higher-level trauma centers. Include:

A: Patient populations to transfer age and/or injury based.

B: Decision making process.

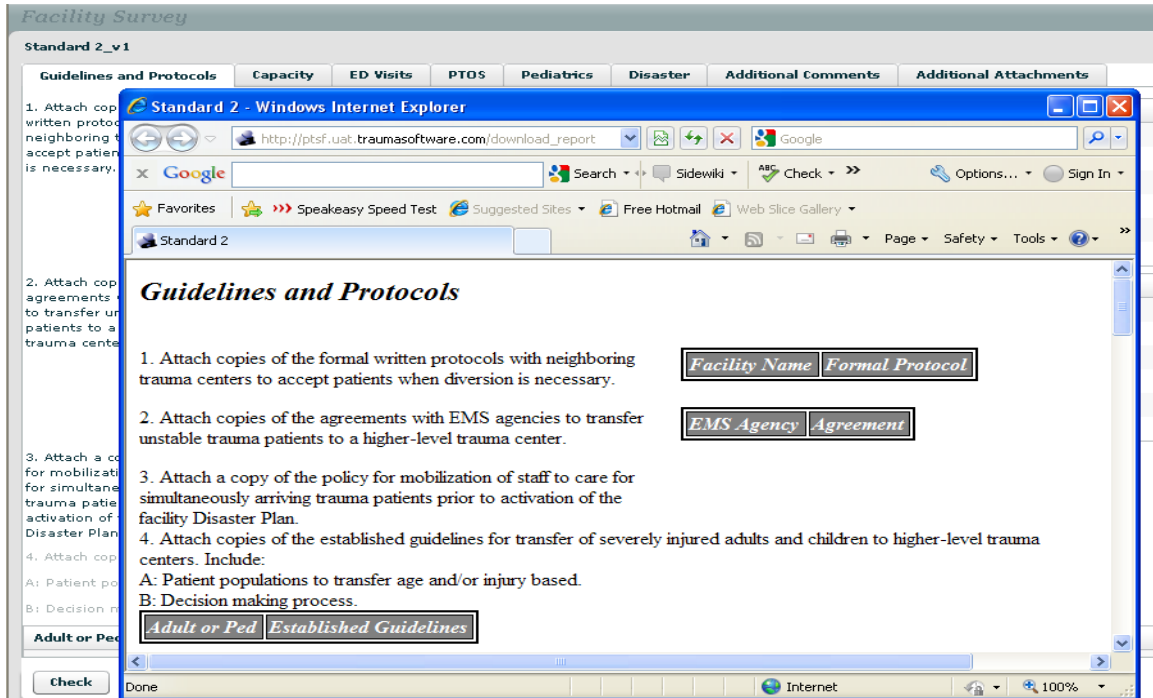
Adult or Ped

Established Guidelines

Check Close **Print** Prev Next Export

Indicate the name of the trauma center with each attached protocol.

- When you click **“Print”** another web page will appear with the standard in a printable format. Click on the **“Printer Icon”** in the toolbar and the standard form will print. Please note that any attachments associated with this standard will be listed by name and number at the bottom, but will not print when using this method.



Printing the Attachment Only

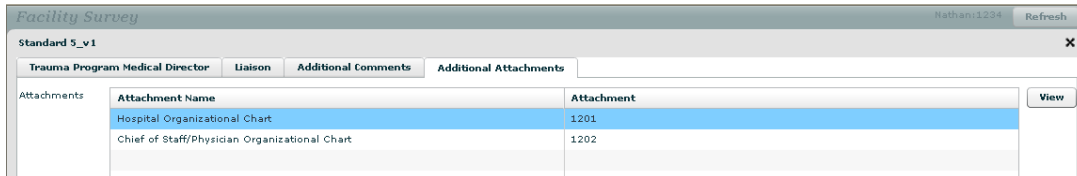
- Double click on the standard you would like to print to open it.

Facility Id	Standard Name	Standard Description	Completion Status	Review Status	Last Modified Date
0204	Standard 2_v1	Capacity and Ability	Active	Pending	2010-01-21 15:20:18.19300
0204	Standard 3_v1	Helipad	Active	Pending	2010-02-05 16:14:28.57100
0204	Standard 4_v1	General surgery residency pr	New	Pending	2009-09-24 17:10:21.85300

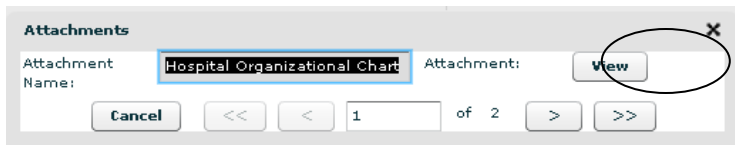
- Once in the standard, click on the **“Additional Attachments”** tab.

Attachment Name	Attachment
Pediatric Trauma Alert Notification Process	1166

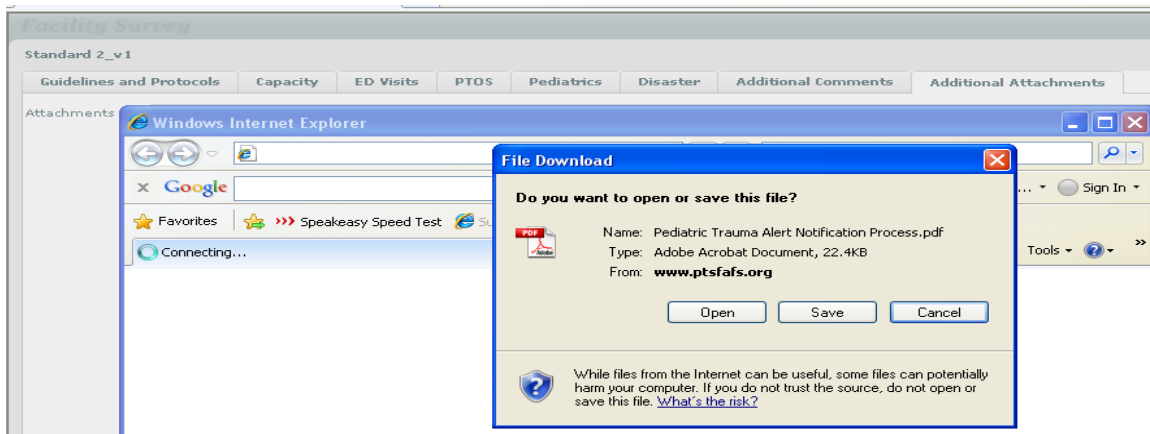
- Double clicking on an attachment line will bring up an “**Attachments**” box from which you can then click on the “**View**” button.



- Click the “**View**” button.



- A File Download box will then appear asking you to **Open** or **Save** the pdf or image file.



- Clicking on “**Open**” will open the attachment in adobe. Once adobe is open you may print the attachment in the same manner you would any pdf document.

## Printing the Standard and Attachments Together

1. Double click on the standard you would like to print to open it.

Facility Id	Standard Name	Standard Description	Completion Status	Review Status	Last Modified Date
0204	Standard 2_v1	Capacity and Ability	Active	Pending	2010-01-21 15:20:18.19300
0204	Standard 3_v1	Helipad	Active	Pending	2010-02-05 16:14:28.57100
0204	Standard 4_v1	General surgery residency pr	New	Pending	2009-09-24 17:10:21.85300

2. Once in the standard go to the bottom of the screen and click “Export”.

**Standard 2\_v1**

**Guidelines and Protocols**

1. Attach copies of the formal written protocols with neighboring trauma centers to accept patients when diversion is necessary.

2. Attach copies of the agreements with EMS agencies to transfer unstable trauma patients to a higher-level trauma center.

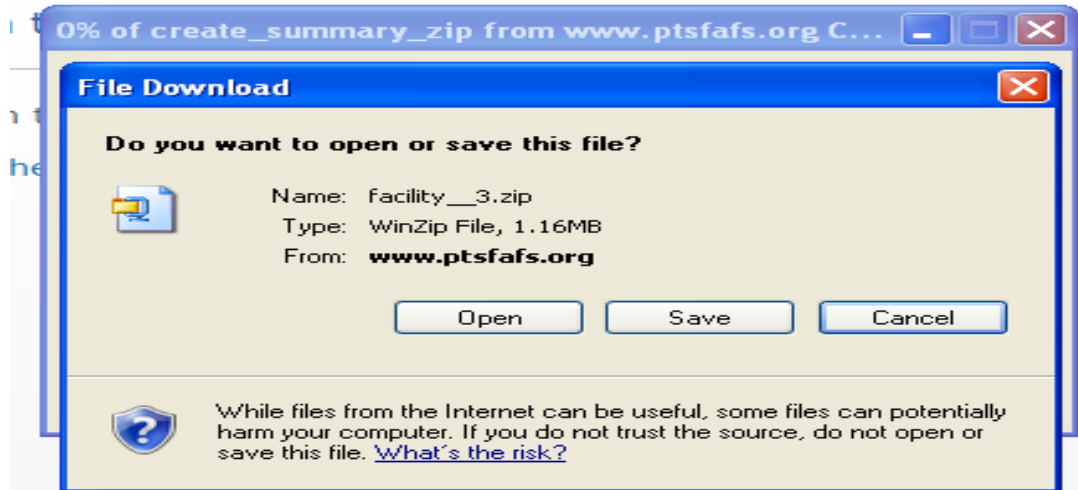
3. Attach a copy of the policy for mobilization of staff to care for simultaneously arriving trauma patients prior to activation of the Facility Disaster Plan.

4. Attach copies of the established guidelines for transfer of severely injured adults and children to higher-level trauma centers. Include:  
 A: Patient populations to transfer age and/or injury based.  
 B: Decision making process.

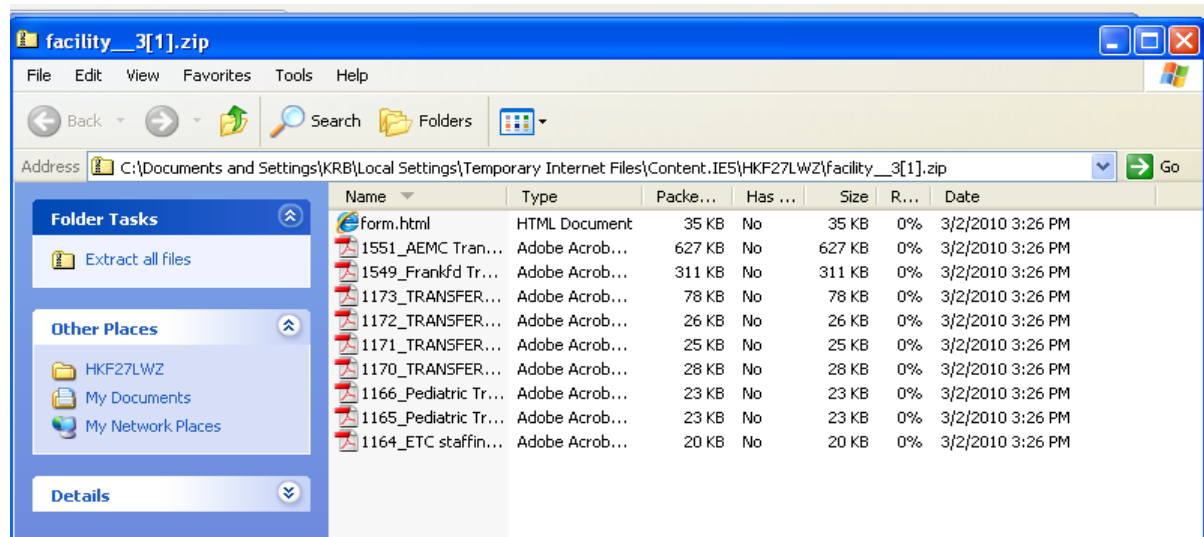
**Adult or Ped** | **Established Guidelines**

**Check** **Close** **Print** **Prev** **Next** **Export**

- Clicking the export button will bring up several screens at once with the last screen being the File Download screen. A zip file has been created that you can either open at this point or save to another location to open later. Click "Open".



- Double clicking on any of the Adobe file will open the document in Adobe. Once adobe is open you may print the attachment in the same manner you would any pdf document. Double clicking the form.html will cause another web page to appear with the standard in a printable format.



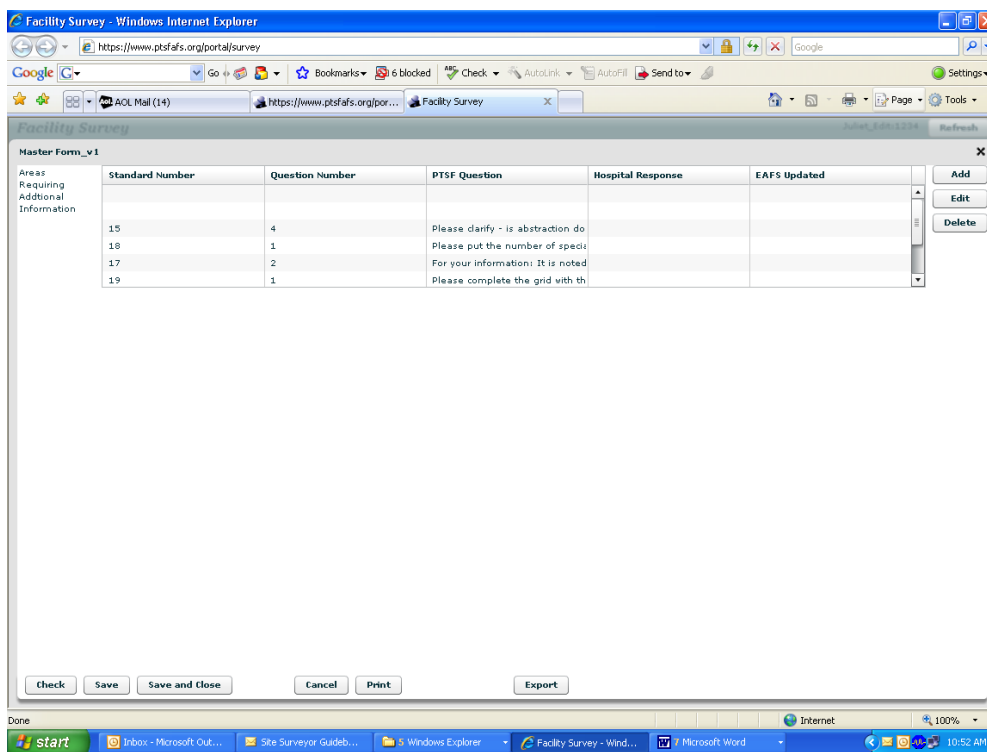
### Location of issues identified by PTSF Staff: the Master Form

After a trauma center completes the EAFS, PTSF staff reviews it in its entirety and asks clarifying questions in the **Master Form** located in the record manager after standard 37. A deadline of 2 weeks is given for the trauma center to respond to the question either directly in the masterform and/or by changing the content within the EAFS. After the clarifications are completed PTSF reviews the answers once again and if the question is still not meeting the standard or remains unclear, the review status column within the **record manager** screen will say **“Action Required”**. This means that the survey team will need to seek further clarification from members of the trauma program on survey day.

Other options noted in this column are as follows and pertain only to the trauma center user:

- **Pending:** This signals the trauma center that PTSF staff has a question regarding their answer. Details can be found in the Master Form.
- **Accepted:** No further clarifications from the trauma center are necessary

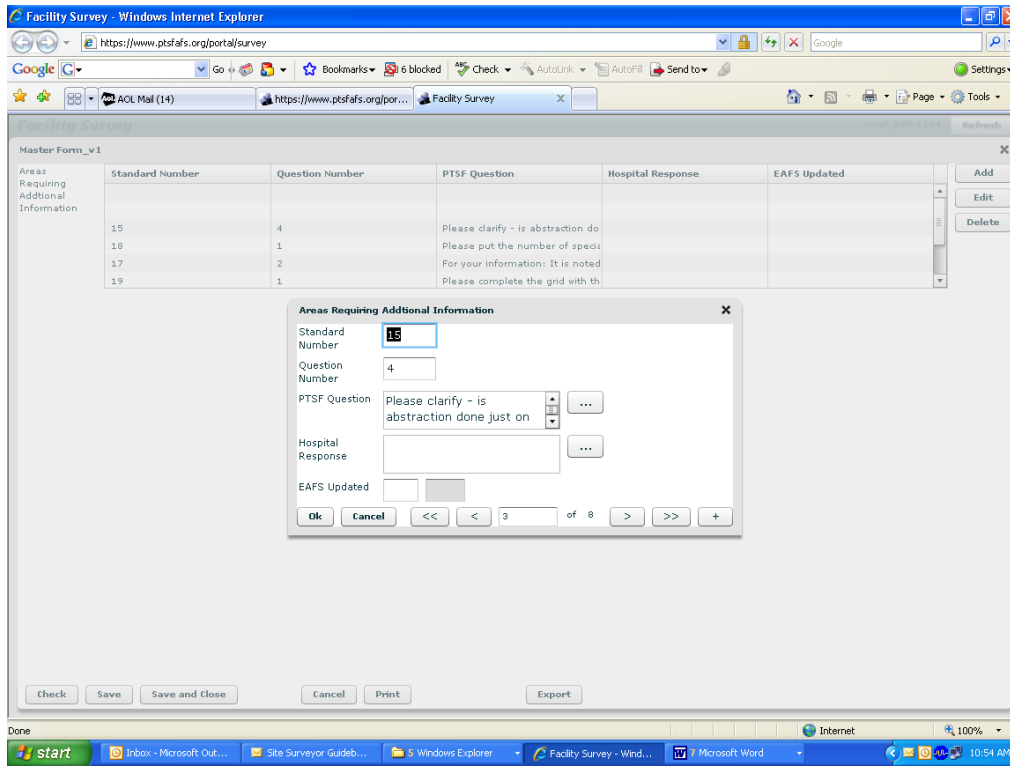
The first screen of the master form looks like this:



Double click on to a line within the grid to bring up a small window that will allow you to view the clarification questions asked of the trauma center. This window is titled **“Areas Requiring Additional Information”**. Trauma centers are asked to revise their original answers in the EAFS or write a comment in the Hospital Response area if:

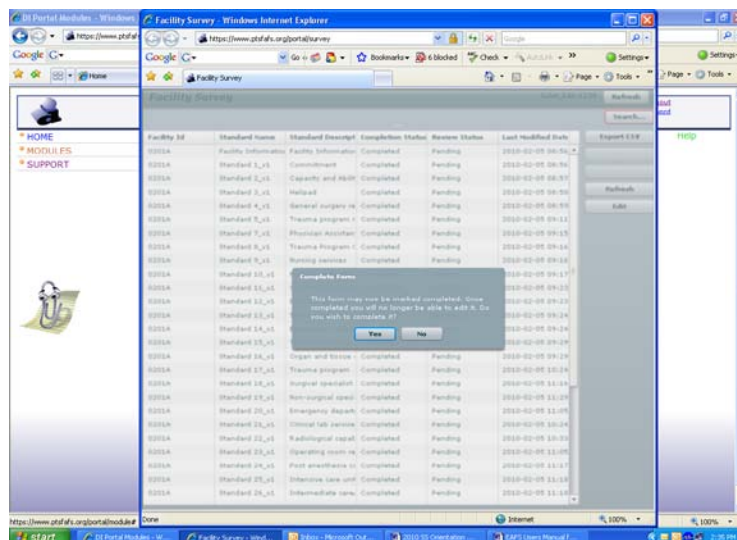
- EAFS revisions are not appropriate
- Further explanation is warranted
- An extra attachment was added.

Example of window showing: “Areas Requiring Additional Information”



Once you are done, click “ok”. To get out of the master form, click “save and close” located at the bottom of your screen.

A window will now appear saying that if you click “yes” the Master Form will be closed and no longer accessible. Please click “no” if you wish to continue to be able to access it.



## Appendix C

### ACS vs. PTSF Standards of Accreditation Comparison Document

The Pennsylvania Trauma Systems Foundation (PTSF) must at a minimum meet the ACS COT criteria for standards for levels of trauma center accreditation.

One exception to this, written into PA legislation, is related to the volume criteria for level one and level two trauma centers. Level one trauma centers must have a PTOS volume of 600 patients per year while level two trauma centers must have a volume of 350 patients per year. The areas where the PTSF exceeds the ACSCOT standards are in the table below:

Standard	PTSF	ACS
II	Individual surgeons must have 50 managed cases per year or 35 with an ISS of 16 or greater.	Also required but can be in lieu of the volume requirement for level one trauma centers.
VI	Board certification required for anesthesia.	Board certification not required for anesthesia.
VII	The PTSF has standards related to the use of Physicians Assistants in addition to CME, and ATLS requirements.	There are no standards for Physician Assistants.
X	The PTSF has specific nursing standards that include an institution specific Trauma Nurse Course, certification requirements, and continuing education requirements as part of the credentialing process.	There are no standards for nursing credentialing, certification, or continuing education.
XI	The PTSF has standards related to the use of Nurse Practitioners in addition to trauma education hours, and ATLS requirements.	There are no standards for Nurse Practitioners.
XVIII XIX	The PTSF has a formal alternate pathway process for non board certified physicians that differs from the ACSCOT. Hospitals submit a request outside the site survey process which is reviewed by staff, the standards committee, and lastly by the PTSF Board of Directors.	The ACSCOT has a formal process that can include a review on site survey day by that sub specialty.

<b>Standard</b>	<b>PTSF</b>	<b>ACS</b>
XXV	Maximum staffing ratio of 1 nurse to 2 patients in the ICU.	No staffing ratio.
XXVI	Maximum staffing ratio of 1 nurse to 4 patients in step-down units.	No staffing ratio.
XXVI	Minimum standards and equipment lists for step down units.	No established standards or minimum equipment for step-down units.
XXVII	Minimum standards and equipment lists for medical/surgical units.	No established standards or minimum equipment for medical/surgical units.
XXXI	The PTSF establishes standards for social services including preparation, job duties, space requirements and continuing education requirements.	No established standards for social work services.
XXXII	The PTSF establishes standards for pastoral care.	No established standards for pastoral care.
XXXVII	The PTSF establishes standards for case management capabilities including participation in national and regional activities, job duties, and continuing education requirements.	No established standards for case management capabilities.
<b>Other Differences</b>		
Transfer Out Guidelines	The PTSF has mandatory transfer out guidelines for Level III trauma centers.	
Data submission	PTSF has criteria for the submission of trauma cases to the statewide trauma registry that differs from the ACS (see Attachment A with Standards of Accreditation document).	The ACS does not have the same inclusion criteria as noted by the PTSF.
Medical Record Selection for Site Survey	PTSF staff selects cases from predetermined criteria (see site surveyor guidebook).	Charts for review by the survey team are selected by the trauma center based on an ACS query that chooses 10 records for given body regions.

<b>Standard</b>	<b>PTSF</b>	<b>ACS</b>
Accreditation Decision	The PTSF Board of Directors determines by blinded ballot the accreditation status of hospitals in Pennsylvania. ACS verification is not recognized in Pennsylvania.	A verification committee determines whether a hospital meets standards and submits results to the hospital and the state agency. The state however may elect to determine independently whether they will designate a hospital.