# Site Survey Guidebook

PENNSYLVANIA TRAUMA SYSTEMS FOUNDATION

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pennsylvania TRAUMA SYSTEMS foundation

# SITE SURVEY GUIDEBOOK

The information in this guidebook will assist in preparation for a consultative survey and/or Trauma Center accreditation site survey. This material was gathered based on Pennsylvania Trauma Systems Foundation (PTSF) staff observations, comments received from applicant hospitals, suggestions received from site surveyors, and recommendations from the PTSF Board of Directors. In addition to the guidebook, please refer to the following additional resources:

- Site Survey page on the PTSF website
- Trauma Accreditation Resources page on the PTSF website
- Home page of the PTSF Central Site Portal; login required

The PTSF hopes that with advance preparation by both the applicant hospital and Site Survey Team, the survey day will flow smooth, surveyors will have the opportunity to engage in open dialogue and gather information on the Trauma Program, system operations, clinical care, and performance improvement (PI). The collection of this information, and the surveyors' recommendations, will be provided to the PTSF Board of Directors (Board) who will determine if the Trauma Center meets the standards of accreditation.

Please share this manual with everyone involved with site survey preparations and the actual site survey visit. Feel free to contact the Pennsylvania Trauma Systems Foundation (717-697-5512) if you have any questions.

*Regarding accreditation & site survey . . .*

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DI by ESO SUPPORT:
For DI by ESO software challenges or issues on the day of survey, call 866-766-9471: Option 3 or e-mail support.ptsf@eso.com and mention that you are having a PTSF survey. While you are on the phone, the operator will route the call to an available technician. An e-mail is prioritized to the front of the queue. PTSF also has the individual technician's phone numbers and e-mail addresses as a backup.

# CONTENTS

# ACCREDITATION PROCESS – PRIOR TO SURVEY

## Letter of Request to Schedule a Consultative Visit or Accreditation Survey

Hospitals pursuing Trauma Center accreditation must submit a letter to request a consultative visit or accreditation survey. Payment of half the Site Survey Fee for New Applicants or Consultative Visit Fee, depending on type of survey request, must accompany the Letter of Request submission.

The PTSF staff is available for education and support to aid in preparation for either type of survey. Accreditation education is required for all new Trauma Program Managers (TPM), Trauma Program Medical Directors (TPMD), and pursuing centers, prior to the first survey. Education is scheduled by PTSF staff. Contact the PTSF Accreditation Coordinator for additional details.

Although a consultative visit is not mandatory, it is strongly recommended for hospitals pursuing Trauma Center accreditation. The intention of a consultative survey is educational in nature. The consultative survey schedule can mirror the process of an accreditation survey, or it can be tailored to your hospital's needs. Scheduling an accreditation survey after a consultative survey should allow for enough time for Board review, report generation, and hospital action plan implementation.

* NOTE: A letter requesting an accreditation survey is not required for currently accredited hospitals.

## Pursuing and Accredited Trauma Center Fees

Site survey fees are available on the PTSF website in the Fee Schedule section of the Resources page. The PTSF Board of Directors approves fees annually. The PTSF emails invoices to hospitals annually (November). For pursuing hospitals planning an accreditation or consultative survey for the first time, half of the fee is due when the Letter of Request is submitted the year prior.

## Application for Survey (AFS)

Trauma Programs must complete an AFS for every site survey. Each fall the PTSF activates the subsequent year's secure web based AFS. Complete the AFS through the Central Site Portal, which is supported by Digital Innovations, inc. by ESO (DI by ESO). The site can be accessed at https://ptsf.centralsiteportal.com/#/. Each applicant hospital has one login provided to the TPM. Information in the AFS creates the first impression of the hospital for the Survey Team. Answer questions accurately, succinctly, and completely. Assure that all answers demonstrate your hospital's compliance with the Standards of Accreditation.

Data requested in the AFS can be obtained from standardized reports: "Core Measures and AFS Report" and "Transfer Summary Statistics Report." Additional details on how to complete the AFS are available in the AFS User Manual located on the home page of the Central Site Portal. This guidebook includes a comprehensive list of reports and attachments required in the AFS, and frequently asked questions.

AFS due dates are assigned based on the site survey schedule. Typically, this includes:

- Hospitals surveyed between January and June – Due January 31st
- Hospitals surveyed between July and December – Due May 1st or June 1st

*DUE DATES ARE ASSIGNED BY THE PTSF AND ARE LISTED ON THE SAVE THE DATE NOTICE!*

After the Trauma Center completes the AFS, submit via email to the lead PTSF staff member for your hospital's survey. No action is required within the AFS software to 'submit' the AFS. The PTSF staff will then place the AFS in view-only mode and complete a preliminary review. Hospital staff will be notified (via the Clarification Form within the AFS) if any clarifications are required and provided with a deadline for final completion. All clarifications are made directly in the AFS. The Survey Team is granted view-only access to your AFS approximately a month prior to survey. The Survey Team will validate that information provided in the AFS meets the Standards of Accreditation and standard trauma care.

## Required Forms

In addition to the AFS, hospitals must submit the following forms to the PTSF prior to survey.

1. Site Survey Schedule & Participants – Provides schedule, logistical, and participant information. Due to the PTSF, via email, three weeks prior to the survey date. The PTSF staff will provide this document.
2. Alternate Pathway Provider Medical Record Form – Applicable only for hospitals with providers who participate in a temporary or permanent Alternate Pathway. This form provides the PTSF with a list of medical records, which include Alternate Pathway provider involvement, from the medical records query. This form is due to the PTSF via email one week prior to the survey date.

## Site Survey Preparation

In preparation for your hospital's site survey, the trauma program should consider the following options:

- CONSULTATIVE (MOCK) SURVEYS conducted by internal staff or Trauma Program personnel from other Trauma Programs are helpful in program assessment and identifying opportunities to improve the Trauma Program/presentation prior to survey. For hospitals that utilize an electronic medical record, external review is especially important to identify the ease with which a surveyor will be able to navigate the medical record and assess clinical care.

- EXTERNAL PEER REVIEW is used by many hospitals on a case-by-case basis to conduct additional peer review on selected patient records. This provides an unbiased evaluation of patient care and the peer review process and may identify opportunities to further enhance patient care or the Trauma Program.

NOTE: DO NOT choose the PTSF's Board Members to conduct consultative (mock) surveys, provide External Peer Review, or for consultative services within three years of your survey. Based on the PTSF's Conflict of Interest Policy, Board Members are not able to participate in the accreditation deliberations for the hospital.

# SITE SURVEY VISIT

## Accreditation Survey

The purpose of the accreditation survey visit is to evaluate whether an applicant hospital is in compliance with the PTSF Standards of Accreditation. This is applicable to both existing Trauma Centers undergoing a re-accreditation visit and hospitals pursuing new Trauma Center accreditation. Hospital's pursuing accreditation must demonstrate compliance with preparations for site survey as noted in PTSF Policy AC-130 Process for Becoming an Accredited Trauma Center. Evidence of Standards compliance is measured by:

- Appropriate and timely clinical management of the trauma patient as documented in the medical record.
- Trauma Center/system PI and its integration into the hospital's PI program.
- Policies, procedures, protocols, and patient management guidelines focusing on clinical and fiscal administration of the Trauma Center.
- Education and training of the Trauma Center personnel in clinical management of the trauma patient.
- Participation of required clinical personnel in the trauma center.

The PTSF staff reserves the right to terminate a site survey if the site surveyors' ability to carry out their responsibilities in conducting a survey is impeded in any way. Examples of this include:

- A Trauma Program staff member who exhibits behaviors that impede the ability of the surveyors to openly discuss cases and review charts.
- Lack of access to electronic medical records due to technical difficulties or other reasons.
- Falsifying documents under review by the PTSF surveyors, including medical records, PI information or policies.

In the event a survey is cancelled due to the above circumstances a hospital may be at risk for suspension or de-accreditation.

*The goal of the PTSF staff is to provide an environment that allows a comprehensive review of the trauma program and to foster dialogue between the site surveyors and hospital personnel. The process that is utilized is consistent throughout all site surveys. The PTSF requests and appreciates the trauma program's cooperation.*

## Consultative Visit

A consultative visit, led by the PTSF, is generally similar to a typical accreditation survey. The purpose of the consultative visit is educational in nature and seeks to duplicate the format of the accreditation survey as closely as possible. The consultative visit will differ because more time is given to education and less time to medical record review. Keeping this in mind, the daily schedule for the consultative visit may be customized based on the hospital's needs, Consultative Team composition may be customized as well (for example, one surgeon and one nurse instead of two surgeons and one nurse etc.). Please contact the PTSF Director of Accreditation to discuss consultative survey options.

The Board will review, analyze, and then provide recommendations to the hospital based on Consultative Team's review. A consultative visit report will be generated and will typically include the following sections: commitment, clinical care, performance improvement, medical record review, and summary. The consultative visit report submitted to the hospital is not shared with future site Survey Teams or with the Board in future deliberations. Although not required, consultative surveys are highly encouraged.

## Level IV Panel Survey

Level IV Trauma Centers on a four-year survey cycle will have a mid-cycle Panel Review during year two of the survey cycle. Refer to Policy AC-139 for details.

# SURVEY TEAM

## Survey Team Composition

The Survey Team consists of a combination of the following depending on the needs of the institution and type of survey:

- Trauma Surgeon Team Leader (TSL)
- Trauma Surgeon (TS)
- Registered Nurse (RN)
- Emergency Medicine Physician (EM)
- Neurosurgeon (NS)
- Orthopedic Surgeon (OS)

Refer to PTSF Policy AC-119: Surveyor Selection Criteria for team composition guidelines.

CONFLICTS OF INTEREST: Trauma Centers are notified of the proposed members of the Survey Team as soon as possible. The PTSF adheres to a strict conflict of interest policy when assigning site surveyors. Hospitals also have the opportunity to submit any site surveyor conflicts, within 30 days of notification of the team composition. Please note, conflicts should be conveyed to the PTSF as soon as possible to avoid having to reschedule the survey date and incur extra fees.

Additionally, two PTSF staff members are present at all surveys. One staff member is assigned the PTSF Staff Lead for the survey and is the point of contact for the hospital.

NOTE: In the event a hospital elects to change the date of or cancel a site survey that has already been scheduled, the hospital will be responsible for all charges incurred to that point. Charges will not be incurred if the rescheduling is caused by the site surveyor. Refer to PTSF Policy BD-113: Payments & Refunds of Fees for additional details.

NOTE: In the event that the PTSF must cancel and/or reschedule a site visit due to the absence of one or more team members, please refer to PTSF Policy AC-133: Team Member Attendance/Cancellation for Site Visits for additional details.

## Site Surveyor Preparation

The following information is provided to the Site Survey Team prior to arrival at the hospital:

- PTSF Standards of Accreditation.
- Site Surveyor (DI by ESO) software tutorial.
- The specific Trauma Program's AFS.
- Trauma registry data outlining demographic information (for example, ISS, age, and mechanism of injury) and hospital event frequency report.
- Significant Issues identified from the most recent site survey visit, if applicable. The Surveyors do not receive the medical record portion or lists of Strengths and Opportunities for Improvement from previous accreditation reports.
- If a hospital failed to receive accreditation during its first visit and reapplies, the previous accreditation report is not shared with the new team.
- If a hospital had a previous consultative visit, the consultative visit report is not shared with the new team.

The Surveyors also participate in a Survey Team Orientation conducted by the PTSF staff and are provided education via webinar for the AFS prior to the survey date.

# SITE SURVEY SCHEDULE

There is a considerable amount of information to cover during the survey day. Surveyors are oriented to Pennsylvania's survey process, time schedule, and their individual responsibilities prior to survey day. Please share this information regarding the time schedule with all staff participating in the site survey process. While open dialogue is encouraged, please provide clear, concise responses to questions. Provide documentation and/or examples to answer the question or resolve the issue. Please recognize that the Surveyors adhere to a strict time schedule and may find it necessary to move on to another issue. Audio or video recording during the survey is not permitted.

There are occasions when Surveyor(s) require additional time to complete the review. If it is anticipated that additional time will be required and the time schedule must be adjusted, hospital staff will be notified as soon as possible.

The time schedule may be modified to accommodate an earlier/later start time, additional time for a session, or to include special survey schedule items based on the applicant hospital's status. Schedules often change for hospitals undergoing their first survey, those without significant issues, or those with multiple significant issues. The PTSF staff will provide the Trauma Program with the survey schedule. Please contact the PTSF staff to request modification of the provided survey schedule, if applicable.

Time is crucial. Make every effort for close proximity of meeting locations. This reduces the amount of time required to organize participants for the meeting and travel between survey day sessions. The PTSF recommends assigning someone other than the TPM or TPMD to assist in getting the participants organized and in the correct location, ready to begin on time.

The following section contains time schedule samples for the survey day. ***Please keep in mind that the following times may change during the course of the survey day based on the time it takes for the Surveyors to accomplish their tasks for each session***. If there are any changes to the site survey time schedule, the PTSF staff will communicate these changes with Trauma Center staff as soon as possible. In some circumstances the Survey Team is ready to begin survey day or sessions early, therefore, as a best practice, hospitals participants should be prepared to begin a session early.

2024 PTSF Surveys can be in the traditional survey format with all hospital participants in person. If the hospital's policy for in-person meetings limits attendance, then a hybrid format for the survey is acceptable, where some participants may participate via a video conferencing platform (i.e., Microsoft Teams, Zoom, GoToMeeting, WebEx). The operation of a video conferencing platform requires assigning a Video Meeting Coordinator, who cannot be the TPM or TPMD, but may be IT personnel, an Administrative Assistant, or another identified role.

# TYPICAL Site Survey Schedule: Level I, II and III

| TIME | ACTIVITY |
|---|---|
| 0645 - 0700 | Survey Team Arrival & Brief Introductions |
| 0700 - 0715 | Opening Conference by Trauma Center Staff<br>*PTSF Staff Lead will open and introduce the Survey Team |
| 0715 - 0800 | Physician Group Meeting<br>(concurrent with)<br>Nursing & Collaborative Services Group Meeting |
| 0800 - 0845 | Significant Issue Presentation (n/a for new applicants) & Performance Improvement Overview |
| 0845 - Noon | Medical Record Review |
| Noon – 1230 | Lunch (Private for Survey Team) |
| 1230 - 1600 | Medical Record Review Continues<br>• May include hospital tour TBD |
| 1600 - 1700 | Survey Team Discussions (Private for Survey Team) |
| 1700 - 1730 | Leadership Closing Meeting |

NOTE: Consultation site survey schedules typically mimic the accreditation survey schedule; however, they may be adjusted based on the needs of the hospital. Please contact the PTSF Staff Lead assigned to your survey to discuss consultative survey schedules.

# TYPICAL Site Survey Schedule: Level IV

| TIME | ACTIVITY |
|---|---|
| 0645 - 0700 | Survey Team Arrival & Brief Introductions |
| 0700 - 0715 | Opening Conference by Trauma Center Staff<br>*PTSF Staff Lead will open and introduce the Survey Team |
| 0715 - 0800 | Physician, Nurse & Collaborative Services Group Meeting |
| 0800 - 0845 | Significant Issue Presentation (n/a for new applicants) & Performance Improvement Overview |
| 0845 - Noon | Medical Record Review |
| Noon - 1230 | Lunch (Private for Survey Team) |
| 1230 - 1600 | Medical Record Review Continues<br>• May include hospital tour TBD |
| 1600 - 1700 | Survey Team Discussions (Private for Survey Team) |
| 1700 - 1730 | Closing Leadership Meeting |

NOTE: Consultation site survey schedules typically mimic the accreditation survey schedule; however, they may be adjusted based on the needs of the hospital. Please contact the PTSF Staff Lead assigned to your survey to discuss consultative survey schedules.

## TYPICAL Level IV Mid-Cycle Panel Review Schedule

Typical length of a Panel Review is 1.5 hours. The review occurs remotely over a video conference platform of the hospital's choice (i.e., Microsoft Teams, Zoom, GoToMeeting, WebEx). Start time will vary and is assigned by the PTSF. This example Panel Review Schedule has a start time of 2:00 p.m.

| TIME | ACTIVITY |
|---|---|
| Pre-Arrival | Survey Team Preparation (Private for Survey Team) |
| 1400-1530 | Trauma Center Presentation<br>• Brief introductions<br>• Hospital & Trauma Program Overview<br>• Significant Issue Progress<br>• AFS Follow-Up<br>• 3 Case Presentations<br><br>Closing Discussion |
| Post-Presentation | Survey Team Completes Board Recommendation Report (Private for Survey Team) |

## Survey Day Schedule Details

Survey Team Arrival

The mandatory and recommended participants for each session of the survey day are identified in the Appendix. The schedule starts with the early arrival of the Survey Team and the PTSF staff. To facilitate a smooth transition into the survey day, please provide the following:

- A designated parking space close to the hospital entrance for the Survey Team vehicle. If possible, please provide the PTSF staff with a map that identifies the parking location.
    - Level IV Trauma Centers – the PTSF may request more than one designated parking space.
- TPMD and TPM meet the Survey Team members at the specified entrance and escort them to the opening conference location.
- Light refreshments, coffee, juice, water, and light continental breakfast during the morning hours and beverages/snacks for the afternoon. Healthy snacks are encouraged. The Survey Team prefers a warm lunch. (Any food/beverage charges incurred for the Survey Team and the PTSF staff may be submitted to the PTSF office. Only charges incurred by the Surveyors and the PTSF staff are reimbursed).

The main objective is for the Survey Team to meet the key members of the trauma staff and selected members of the Trauma Center. A light breakfast, including beverages should be available during this meet-and-greet time. After the initial introductions, the Survey Team will move immediately to the Opening Conference. If surveyors are ready to proceed with Opening Conference prior to the scheduled time, the opening conference will begin early.

### Opening Conference Session

The PTSF Staff Lead will make brief opening comments and the Survey Team will make their own introductions. Introductions are followed by a short presentation from the CEO, Board Member, and/or Trauma Program staff member who shall present information unique to their hospital. Topics that must be presented include:

- Identification of Trauma Program and Service staff.
- Significant hospital and program changes since the last site survey.
- Map of Pennsylvania that identifies the exact location of the hospital.
- Catchment area and community demographics.
- Trauma Program demographics including volume

Discussions about significant issues and PI projects should be reserved for their scheduled session. Keep the presentation succinct. This session may be extended if mutually agreed upon between the hospital and PTSF staff prior to the day of survey. If extended, other sessions will be flexed to accommodate the change.

#### *Room Preparation*

- Provide a large room with enough space for U-shaped table seating. Provide easily readable name tents (with title in large font and name on both sides) for all participants in the room including the Survey Team and the PTSF staff. Please position The Survey Team and the PTSF staff together at the table.
- If you use an auditorium for the Opening Conference, provide identifiable seating for the Surveyors and the PTSF staff, and define the core group of individuals that will be formally introduced for the meeting. Please minimize formal introductions during the opening conference to ensure the surveyors hear as much information about the trauma program as possible.

- Provide each member of the Survey Team and PTSF staff with a folder containing:
    - The agenda with session times, locations, and participants for each session
    - Names of personnel at each session of the survey
    - All presentation slides that may be used throughout the day and other information of interest (i.e., hospital newsletters, Trauma Center timeline for program implementation, etc.). No more than TWO SLIDES PER PAGE, can be double sided and in black or grayscale
    - Criteria for trauma alert activation
    - For PTSF Staff Lead only – Nursing Education & Credentialing Site Survey Report, and any additional documents requested in the AFS Clarification Form if not previously submitted via email
- Display posters, awards, newsletters around the perimeter of the room. These can be moved into the Medical Records Review Room.

### *Staff Preparation*

Alert the staff that all members should be present by 6:45 a.m. (or 15 minutes prior to the start time) and in welcoming mode! Enthusiasm sets a positive tone for the day. This is an opportunity to shine! See checklist located in the Guidebook Appendix to aid in preparation for this session.

## Physician, and Nursing & Collaborative Services Group Meetings Session

Level I-III Trauma Centers: The Physician Surveyors will meet with hospital physicians and Liaisons to gather information on how trauma care is delivered by each team member, how various specialties interact with one another, and how they are involved in trauma PI. This gives Surveyors the opportunity to understand how the Trauma Program functions within the hospital. The session is facilitated by the TSL and is limited to 45 minutes.

The Nurse Surveyor will meet with hospital nursing and collaborative services staff members to obtain information pertaining to nursing and collaborative services care delivery to trauma patients, the interaction between the trauma service and the various nursing units/collaborative services staff, and their involvement in trauma PI. The session is facilitated by the Nurse Surveyor and is limited to 45 minutes.

Level IV Trauma Centers: This is a combined meeting where both the Physician and Nurse Surveyors will meet with all physicians, nurse, and collaborative services hospital staff. The Surveyors gather information on how trauma care is delivered at the hospital, how the different physician groups, nursing and collaborative services interact with each other, and their involvement in trauma PI. The session is facilitated by the Physician Surveyor.

At all site surveys a PTSF staff member will be present in the room for this session. They do not need to have a seat at the table.

### *Room Preparation*

- Provide a room for each meeting with enough space for U or square-shaped table seating.
- Provide name tents (titles and names on both sides) for the attendees and Surveyors.
- Keep in mind travel time/distance between meeting locations. The time schedule is very tight, and extra travel may be disruptive.

### *Staff Preparation*

Limit the number of participants to those that are essential (20 or less). Each hospital participant should be able to provide specialty-specific information and articulate any changes that have been made which affect trauma clinical care and the Trauma Program.

The TPMD and TPM *should not* answer all of the questions. They can direct the question to another

participant. Each participant should be prepared to discuss their specialty, their relationship to the Trauma Program and overall trauma PI activities.

## Significant Issue Presentation & Performance Improvement Overview Session

Trauma Centers with significant issues identified from the previous survey must utilize this time to present each significant issue AND the PI process. It is important that the trauma program use this time wisely to thoroughly address both topics. The PTSF recommends presenting the significant issues prior to the PI process. Please provide copies of the PowerPoint presentation (2-slides per page, on both sides, black or grayscale is acceptable) to the Surveyors and the PTSF staff. If you anticipate problems staying within the required timeframe, contact the PTSF Staff Lead assigned to your hospital to discuss alternate schedules.

### Significant Issue Presentation:

This is an opportunity for Trauma Program staff to present a summary of efforts used to resolve significant issues cited on the previous site survey. It is the responsibility of the Trauma Program to clearly demonstrate resolution of the previous significant issues during this presentation. Present each significant issue separately. The summary of each significant issue should include the identified opportunities for improvement, the corrective actions taken, committee involvement, multidisciplinary involvement, and most importantly, quantitative data that supports resolution. All significant issues are presented to the entire Survey Team. The hospital staff that was made accountable for the significant issue may be involved in the presentation. Presentation of data is key! Charts and graphs are a great way to present the data to demonstrate resolution of the issue.

NOTE: It is recommended that Trauma Centers utilize the significant issue format from the AFS as an outline to present each significant issue. In addition to the presented summary, have available all documentation of the evidence of the action plan, implementation, and loop closure for each issue. This may be in a binder or available electronically with all supporting documentation available for the Surveyors to review.

### Performance Improvement Overview Presentation:

The focus of this part of the session is to describe the Trauma Program's PI Program. This must include:

- All Trauma Centers: a brief overview of the PI process outlined in the program's PI Plan.
    - At a minimum, the presentation must include all four levels of review and committee structure.
- Level I, II, and III Trauma Centers only (excluding pursuing and provisional site survey): an example of the Trauma Quality Improvement Program (TQIP) report utilization since previous site surveys.
    - The goal is to demonstrate that the Trauma Program utilizes the TQIP reports to impact care at their Trauma Center. The PTSF does not expect improvement in TQIP data or for Trauma Centers to achieve complete resolution prior to the presentation.
    - Present the opportunities for improvement and actions taken to improve patient care or registry data quality from the evaluation of the TQIP report.

If time permits, include examples of successful and complete (through resolution supported by data) PI projects that have been undertaken since the previous site survey.

#### *Room Preparation:*

- Provide a room with enough space for appropriate trauma team members, the Survey Team, and the PTSF staff.
- Provide name tents (title and names on both sides) for the attendees, the Survey Team, and the PTSF staff.
- Provide copies of the presentation slides for the Survey Team and PTSF staff. No more than two slides per page; on both sides and in black or grayscale are acceptable.
- Posters can be used to showcase PI initiatives and may be displayed in the room where this

session is being held or in the room where medical record review is being held.
- The PTSF Staff Lead attends this meeting.

- Note that during this session the second PTSF staff member will proceed to the medical record review location. They will organize the medical records assigned to each Surveyor and set up the Site Surveyor Software for each Surveyor prior to the start of the medical record review. A member of the hospital staff, ideally one of the chart navigators, will need to escort the PTSF staff to the room where medical records will be held and remain in the room during set up. The computers must be powered and ready to navigate the internet. It is recommended that the escort be able to log into the computers or to have IT is present while the PTSF staff sets up.

## Medical Record Review

Most of the day is spent on medical record review where the Surveyors will review the clinical care provided to trauma patients and the PI process completed by the Trauma Program. Clinical care is reviewed from pre-hospital to follow-up post-discharge if applicable. The quality and timeliness of care provided is assessed through documentation in the patient's medical record. The PI process is assessed through the documentation of PI in Pa V5 Outcomes and additional supportive documentation provided by the Trauma Program. Every component of the PI process must be clearly demonstrated in the PI documentation. Surveyors also evaluate meeting discussions.

In the PI process evaluation, the Surveyor will be looks for documentation and evidence of
- Issue/event identification
- Analysis
- Levels of review to include meeting minutes if there was a tertiary review
- Determinations of opportunities for improvement
- Corrective actions
- Implementation of corrective action
- Post-action re-evaluation
- Data to support loop closure
- Loop closure

The PTSF recommends that Trauma Programs provide each surveyor a copy of any PI dashboards or practice management guideline tracking logs as part of the evaluation of the PI process.

There are occasions when Surveyor(s) require additional time to complete the medical record review. The PTSF staff will notify hospital staff as soon as possible if Surveyors anticipate the medical record review will require additional time and a schedule adjustment.

### *Medical Record Selection*

Medical records are selected by PTSF using the Pennsylvania Trauma Outcomes Study (PTOS) Central Database. Only PTOS patients will be selected. Records will be selected according to the type of survey and the date of survey. All medical records from the survey cycle are eligible to be selected, though to review more recent cases the below dates are typically used but may be altered based on the needs of the query base.

- Accredited Trauma Center with two or three-year survey cycle: January 1st of the previous year through date of survey
- Trauma Center with one-year survey cycle: Date of accreditation certificate through date of survey
- New Applicant/Pursuing Center: January 1st of the survey year through date of survey

The PTSF Data Analyst queries the PTOS Central Database with a unique formula to obtain medical records that represent the specific Trauma Center. The medical record selection query typically incorporates distinct indicators that include BUT ARE NOT LIMITED TO:

- Injury Severity Score > 16
- Revised Trauma Score ≤ 7.56
- Patients with extremes of age; ≤ 14 years and ≥ 65 years
- Deaths
- Transfers into or out of the Trauma Center
- Burns (for non-burn centers)
- Hospital events/occurrences with special attention given to:
  - Coagulopathy
  - Acute respiratory distress syndrome (ARDS)
  - Deep vein thrombosis
  - Extremity compartment syndrome
  - Wound infection (traumatic/incisional)
  - Pressure Ulcer
- ICU length of stay: >2 times the hospital average or >2 times the PTOS average, whichever is greater
- Unexpected Outcomes: Survivors and Deaths

The final medical record selection includes a combination of the Trauma Center's typical population and injury pattern, as well as high-risk, low-volume patients. Approximately 10 cases per Surveyor are selected using the above query. A maximum of 2 death records per physician Surveyor are selected. If the number of cases generated in the initial query is too few, some components of the query are expanded (i.e., ISS will decrease to 9) and additional records are selected if necessary.

Three weeks prior to the site visit, the list of selected medical records is sent via a secure email to the TPM by the PTSF Data Analyst. If a hospital is not concurrent (within six weeks of discharge) with PTOS data submission, additional medical records may be selected and communicated to the TPM one week prior to the site visit.

Once you receive the list of medical records via email from the PTSF, please do not alter these medical records in Collector. This information is placed into the Site Survey Software in preparation for the site visit. If you have any questions about the medical records, contact the PTSF Staff Lead immediately.

Alternate Pathway: Medical records selection that includes care by providers on an Alternate Pathway must be identified one week prior to survey day to complete the Alternate Pathway Provider Medical Record Form. Template is available on the Site Survey page of the PTSF website.

### *Site Survey Software Screenshots*

The Board requires Surveyors to communicate their survey day findings via the DI by ESO Site Survey Software. This web-based documentation tool includes sections for the Surveyors to document their review of each medical record, their findings on the previous significant issues, requested queries, overall summary of the Trauma Program, overall summary of the PI Program, strengths, and areas for improvement.

In their review of the medical records, the Surveyors respond to specific questions for each phase of care, and rate each phase as either Acceptable, Acceptable with Reservations, or Unacceptable.

- Pre-Arrival Phase
- Resuscitative Phase
- Radiology/CT Phase (Physician Surveyors only)
- Operative Phase (Trauma Surgeon Surveyors only)
- Neurosurgical Involvement (Trauma Surgeon Surveyors only)
- Orthopedic Surgery Involvement (Trauma Surgeon Surveyors only)
- Critical Care Phase
- Step-Down/Floor Phase
- Clinical Care
- Rehabilitative Care Phase (Nurse Surveyors only)
- Discharge Planning
- Performance Improvement

Each phase of care includes questions on care provided during that phase. The Surveyors will also evaluate the quality of care, immediacy of care and documentation of care. The PI section of the Site Survey Software is different from the other sections. In the PI section the Surveyors will enter every hospital event identified by the Trauma Program and evaluate how the event was taken through the PI process. The responses to each hospital event will include if the PI process was appropriate, a list of the corrective actions taken by the program, and if there was loop closure. The loop closure question refers to evidence of loop closure rather than what is documented in PA V5 Outcomes as the loop closure status. The Surveyor will also list and describe all the issues they identified that were not identified by the Trauma Program. For all deaths, the Surveyor will include details on the death review, categorization, and determination. The Surveyor will respond to a question asking if they agree or disagree with the determination by the Trauma Program.

Screenshots of the questions addressed by Surveyors in the Site Survey Software are available for Trauma Programs to review prior to survey day on the home page of the Central Site Portal. The screenshots are available for the Trauma Surgeon Surveyor, Emergency Medicine Surveyor, and Registered Nurse Surveyor. Screenshots are updated annually.

The PTSF recommends that members of the Trauma Program and chart navigators use screenshots in preparation for survey day. Screenshots provide an understanding of what the Surveyors look for during medical record review and will help the chart navigator identify where to find specific information in the EMR. For example, after viewing the screenshots the chart navigator realized that they do not know where to locate abuse screening documentation, prior to survey they may collaborate with their peers to identify this documentation's location. Chart navigators who review the screenshots and practice locating information in the EMR enhance the efficiency of the medical review session of survey day.

Contact the PTSF Staff Lead for assistance if you need help locating the screenshots on the Central Site Portal.

### *Medical Records and PI Documents*

- Electronic Medical Records (EMR):
    - One chart navigator should be assigned to each Surveyor. The chart navigators (not the TPM or TPMD) are hospital staff members familiar with the EMR.

- The chart navigator will help the Surveyor locate pertinent information in the chart.
- The chart navigator must be familiar with the contents of the PI folder. The PTSF recommends that the chart navigator prepares for this role by reviewing the screenshots of the Site Survey Software prior to survey day. The review helps to ensure that the navigator knows where to locate necessary information in the EMR and helps the navigator to anticipate the Surveyor's required questions for each medical record.
- If the chart navigator is unable to locate the requested information in the chart, they should request the assistance of the TPMD or TPM.
- The chart navigator may briefly orient the assigned Surveyor to the EMR and PI folder. Surveyors do not independently navigate through the system, and therefore do not require formal orientation.
- If the Surveyor has a question about the patient case, the chart navigator must alert the TPMD or TPM to respond to the question. Chart navigators are not expected to answer questions about clinical care or PI.

- Paper medical records (if applicable):
  - Recommend: Organize the chart into easily identified sections by phase of care; tab and label each section.
- PI documentation:
  - Each medical record MUST have the accompanying PI documentation available for review by the Surveyor.
    - Include all evidence of loop closure
  - The Surveyor must be able to review the PI process through the documentation in Pa V5 Outcomes.
    - The OUTCOMES: Survey Summary Printout (preferred) or another Case Summary from Pa V5 Outcomes Report Writer must be included at a minimum.
  - All PI documentation can be located in an electronic folder or on paper within a folder/binder.
    - Electronic PI Folder:
      - Each medical record should have an electronic folder on either the Surveyor's computer desktop or chart navigator's computer desktop.
      - Save the Pa V5 Outcomes printout in the patient's electronic folder as a PDF
      - Recommend: Save all supporting documents as PDF files
      - The electronic folder and each document within the folder must be clearly labeled
      - IMPORTANT: If the hospital opts to utilize electronic PI documentation, PTSF Staff must have access to the electronic PI folders. This can be through two thumb drives (1 per each PTSF Staff) returned at the end of survey day, web-based document sharing platform (access limited to the day of survey), 2 hospital computers/laptops (1 per PTSF Staff), or other method the hospital deems appropriate.
    - Paper PI Folder
      - Copy of the Pa V5 Outcomes documentation (Survey Summary is preferred) must be in the folder
      - Include all supporting PI documents in the folder
    - Supporting documents can include but are not limited to:
      - Follow-up letters sent from the Trauma Program
      - Follow-up letters received by the Trauma Program
      - Autopsy
      - Evidence of Education
      - Evidence of Policy and PMG changes
      - Evidence of EMR changes

- Tracking/Trending Logs or Graphs to demonstrate loop closure
- Meeting Agendas
- Meeting Minutes
- Communications such as emails
- Physician report cards or FPPE/OPPE to demonstrate tracking and/or loop closure

- Use the "Information to Have Available for Surveyor Review" located in the Appendix of this Guidebook to aid in preparation for this session.

### *Query*

The Survey Team has the option to request a query from the hospital's trauma registry (Collector) or Pa V5 Outcomes. Surveyors are asked to speak to PTSF Staff prior to requesting a query. Query requests are individualized to the hospital based on information gathered by the Survey Team during the previous sessions and medical record review. Queries are requested in situations where additional information is needed to clarify trends at the hospital and assist the Survey Team in their conclusions about the Trauma Program.

### *Room Preparation:*

Provide a room with sufficient space and work area to hold:

- Survey team, PTSF staff, and Trauma Center staff
- Reliable internet capability
- Power access for two PTSF staff computers
- Refreshments and beverages (billable to PTSF)
- Posters can be displayed to showcase PI initiatives and may be displayed in the PI room and/or medical record review room. Some centers choose to have 'scrolling' slide show presentations which showcase PI, research, and/or prevention efforts.
- Identify an area close to the room for Surveyors to interview hospital personnel and to discuss the PI review
- Identify a printer close to the room. This does not need to be in the medical record review room but should be in close proximity to allow for expedited retrieval of requested reports

### *IT needs for survey:*

***Each Surveyor will need two computers*** (laptops are acceptable but not preferred).

- ✓ Computer #1 - Used by the chart navigator to access the EMR. Ability to view radiographic imaging is required.
- ✓ Computer #2 - Used by the Surveyor to access the Site Survey Software via an internet browser.

- Recommend: A minimum of a 15-inch screen, the larger the better.
- Please assure computers have been turned-on and all updates are completed
- Please assure the computer will not frequently go to sleep. Assure the chart navigator has the computer login information in case it goes to sleep
- Please provide a mouse for each computer and a second mouse attached to the EMR computer for the Surveyor to use (touchpads are not acceptable)
- Please provide a keyboard for each computer (prefer a separate keyboard over the laptop keyboard)
- Test the DI Web Portal to assure connectivity: https://ptsf.centralsiteportal.com/
- Recommend: IT personnel be available in the room prior to the medical record review start time while PTSF is setting up for this session. Throughout the survey day, IT personnel should be readily available if needs arise.
- Please contact PTSF if you have any questions about IT needs.

*Staff Preparation:*

- All chart navigators should be available in the room 15 minutes prior to the medical record review start time. Registrars, PI Coordinators, and Advanced Practitioners on the Trauma Service make excellent chart navigators.
- The TPMD and TPM should be physically present in the room during the entire medical record review.

- Surveyors may ask for Trauma Registry queries during the site survey based on issues of concern identified throughout the day. The ability to "generate" this information in a timely manner is extremely helpful.
- In efforts to keep the chart review process efficient, please keep extra conversations and interruptions to a minimum.

## Lunch

The Survey Team and the PTSF staff will break for lunch for approximately 30 minutes. This is a private lunch for the Survey Team members and the PTSF staff members only. The PTSF requests a warm lunch in a private room All costs associated with lunch for the Survey Team and the PTSF staff may be billed to the PTSF.

## Hospital Tour

The hospital tour may occur during the second half of medical record review session at the discretion of the PTSF Staff Lead and based on the type of survey, new construction in the hospital and progress in the medical record reviews.

1. Hospital's pursing trauma accreditation will have a hospital tour, to include, at minimum the Trauma Bay/ED Resuscitation Room.
2. Trauma Centers with new construction that impacts the Trauma Bay/ED Resuscitation Room will have a hospital tour, to include, at minimum the Trauma Bay/ED Resuscitation Room.

The hospital tour will help the Surveyors to gain an understanding of:

1. The flow of patients through the Trauma Center.
2. Hospital commitment toward providing necessary resources for care of the trauma patient.
3. Hospital bedside staff with knowledge of their role in trauma patient care through personnel interviews.

To facilitate the tour a hospital staff member must accompany each Surveyor. Tour guides should be from the same specialty as the Surveyor (for example a Trauma Surgeon should accompany the Trauma Surgeon Surveyor). Ideally, Surveyors should not tour the same areas of the hospital together, so please arrange for different hospital staff members to accompany them. Tour guides should immediately ask Surveyors which areas of the hospital the Surveyor would like to see, and then plan their routes. Surveyors will know which areas of the hospital they wish to tour, and in most cases, the order in which they wish to tour those units. The following grid notes a recommended tour route; however, the Survey Team reserves the opportunity to request a tour of any area of interest related to trauma patient care. Tours are limited to a maximum of 30 minutes and may be shortened or cancelled at the discretion of the Survey Team and PTSF staff in order to assure enough time for medical record review.

| Recommended Tour Route (3-member team) | |
|---|---|
| Trauma Surgeon Team Leader | Operating Room, Emergency Department, CT |
| Trauma Surgeon/ED Physician Level III | 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 though the patient care flow system |
| Recommended Tour Route (2-member team) | |
| Team Leader and Nurse<br>Begin together in the Emergency Department/Trauma Resuscitation area<br>Then:<br>• Physician: Radiology and Operating Room (if applicable)<br>• Nurse: Patient Floor as applicable | |

### *Staff Preparation*

Please remind hospital staff to be concise yet thorough with their responses when they answer Surveyor questions. Do not be offended if the Surveyor must move on quickly in order to maintain the time schedule. It is imperative that the touring teams take no longer than the allotted time for the tour. It is more about the hallway conversations than looking at equipment or the physical plant.

## Survey Team Discussion (Private)

This closed meeting is held in the Medical Record Review room with only PTSF staff and Survey Team members present. This session provides the Survey Team with dedicated time to discuss their overall recommendations to the Board and allows time to document their recommendations in the Site Surveyor Software. In the software they will comment on any previous significant issues, comment on active variances (if applicable), enter query information, comment on the overall Trauma Program, comment on the overall PI program, list strengths and list areas for improvement. They also prepare comments and/or questions for the Closing Leadership Meeting.

## Closing Leadership Meeting

The Closing Leadership Meeting provides the opportunity for Surveyors to provide their overall feedback to the Trauma Program and hospital leadership. It is also a time for the Survey Team to ask final questions for clarification regarding compliance with the PTSF Standards of Accreditation.

The session starts with a general announcement by the PTSF Staff Lead summarizing the purpose of the closing session and post survey deadlines. It is further explained that the Survey Team are fact finders only and the PTSF Board of Directors has the responsibility for accreditation decisions. Any statements made by the Survey Team are the Surveyors' opinions only. Surveyors are encouraged to be candid but also to refrain from calling issues "significant," as that is the role of the PTSF Board.

The following hospital staff members are required to attend at a minimum:

- Trauma Program Medical Director
- Trauma Program Manager

- Trauma Program Administrator or representative from hospital administration
- Trauma or Hospital PI

Additional attendees are welcome at the discretion of the Trauma Program and hospital administration. For open and candid discussion, please do not exceed 10 participants. If you anticipate greater than 10 participants, contact the PTSF Staff Lead for prior approval. If a significant issue was identified in the previous survey, or issues are identified during the current survey, it is appropriate to include administrators or physician liaisons who have responsibility and accountability for those issues.
NOTE: Please keep in mind that the site survey schedule may vary, depending on the events of the day. Specifically, the start time of the Closing Leadership Meeting may vary. The PTSF team will update the hospital when applicable. It is requested that hospital leadership anticipate this flexible start time.

## Adjournment:

PTSF staff will explain any specific accreditation procedures relevant to the hospital's site survey prior to the team's departure. Please have a member of the Trauma Program staff available to escort the team to the hospital exit, if necessary.

# POST-SURVEY

## Clarification Letter

Post-survey you may decide to submit additional information for consideration as part of accreditation deliberations by the Board. This additional information may include an update on information available on survey day. Alternatively, the Trauma Center may disagree with the Survey Team's fact finding/comments related to the hospital's compliance with the PTSF Standards of Accreditation. If the Trauma Program chooses to submit a clarification letter, the letter must be sent via email to the PTSF Staff Lead. The following components should be included in the letter:

1. A cover letter addressed to the PTSF Staff Lead signed by the TPM AND TPMD.
2. The contents of the cover letter should describe the topic that the Trauma Program is clarifying. If the topic is that the Trauma Program disagrees with comments from the Survey Team, the letter should describe why the program disagrees.
3. Documentation supporting that the hospital met the Standards of Accreditation on the day of site survey as evidenced through a registry query, established policy or other data.
4. Documentation supporting that the hospital post-survey meets the Standards of Accreditation.
5. Blinded documents that do not include any patient names or identifiers. Specific information related to a medical record should be identified by trauma number and medical record number.

Any information submitted by the Trauma Program to the PTSF is redacted (blackened out) before inclusion in the deliberation materials for Board review – please be aware that all identifying characters are redacted to protect the hospital's identity. To every extent possible, please refrain from the inclusion of notes, names, and/or images that identify your Trauma Center. Documents must be received by the PTSF within two weeks of the site survey unless otherwise agreed upon by the hospital and PTSF.

## Survey of the Survey

The trauma program will receive a Survey of the Survey via email from the PTSF. It is requested that you complete the survey to assist the PTSF staff with their performance improvement of the site survey process. The surveys are anonymous and reviewed in aggregate after the deliberation process for all hospitals in the calendar year are completed.

## Accreditation Decisions

The Surveyors and the PTSF staff members are fact finders. The PTSF Board of Directors vote on each accreditation decision. Board members review a blinded copy of the Site Survey Software and discuss the findings of the Surveyors as they relate to each Board member's area of expertise. Votes are conducted with blinded ballots. The PTSF's Legal Counsel counts all votes and a simple majority "yes" vote is required to accredit a Trauma Center. For Trauma Center's on less than a 3-year survey cycle, the decision is communicated to the applicant hospital's CEO via telephone within several days of deliberation.

The Board will identify and decide on significant issues. The definition of a significant issue is a clinical and/or trauma system issue that impacts or has the potential to impact the ability to provide all aspects of trauma care. A significant issue may be associated with any aspect of the Trauma Program included in the Standards of Accreditation. This includes, but is not limited to, the provision of direct clinical care, the support and responsiveness of administration to the needs of the Trauma Program, the care provided by surgical and non-surgical specialties, the care provided by support services, and the thoroughness of Performance Improvement activities. Lack of documentation may be cited as a Significant Issue, as lack of pertinent information implies that clinical assessments and care have not been provided.

The decision of the Board regarding length of the survey cycle and accreditation status is in large part

determined by the following factors:

- Clinical Care
- Performance Improvement
- Hospital Commitment to the Trauma Program
- Compliance with the PTSF Standards
- Resolution of previous significant issues
- Number of current significant issues

Refer to PTSF Policy AC-137: Accreditation Guidelines and Continuum for Board Members for additional deliberation details including potential vote outcomes options.

Conflict of Interest: Prior to deliberations conflicts of interest are identified. Board members who have a conflict of interest with a hospital will not have access to the hospital's deliberation material and will be excused from that hospital's deliberation discussion and vote. Both Board members and hospitals will have the opportunity to disclose and/or identify potential conflicts of interest annually. This is reviewed by the Conflict of Interest Committee prior to the deliberation meeting to determine final conflict of interest. Refer to PTSF Policy BD-106: Conflict of Interest for details.

## Accreditation Announcements

Within several days following Board deliberations, the hospital CEO and Trauma Program Leadership of each surveyed hospital are notified via email regarding the accreditation outcome of their hospital including the length of accreditation.

Communications occur via telephone, not email, in the following situations:

- The hospital is applying for accreditation as a new Trauma Center
- The hospital has been on a survey cycle less than 3 years (Levels I-III) or 4 years (Level IV)
- An Accredited Trauma Center level elevation (for example from a Level II to a Level I status)

If telephone communication is required, the TPM is notified in advance to schedule this call. It is acceptable for the CEO to invite Trauma Program Leadership to take part in these conference calls.

The effective dates of accreditation are the first day of the second month following the deliberation meeting. Refer to Policy AC-114: Certificates of Accreditation for additional details.

It is important for the PTSF to issue a statewide press release regarding hospital accreditation for all hospitals PRIOR to a hospital making the announcement regarding their individual accreditation status. For this reason, the Executive Director will indicate on the deliberation outcome conference call the timing of that event and when it is acceptable for the hospital to distribute their own press release. Hospitals must submit all media communications to the PTSF prior to their release for language review. Please refer to Policy AC-132: Media Notification Regarding Trauma Center Status for additional details.

In addition to the press release the PTSF also notifies the Pennsylvania Department of Human Services (DHS) regarding the change in the accreditation status of any Trauma Center. The DHS in turn will notify all EMS regional directors who educate ambulance providers to ensure adherence to EMS trauma destination protocols. Changes in accreditation status also impacts Trauma Center funding, which the DHS manages.

## Accreditation Reports

Accreditation reports are developed by the PTSF staff using comments from the Board of Directors and Survey Team. An electronic copy of the Trauma Center accreditation report is provided to the hospital's CEO, TPMD, and TPM within three weeks of the deliberation meeting. It is the applicant hospital's responsibility to

ensure that the accreditation report is distributed to other members of the Trauma Program and any other appropriate parties.

The accreditation report will include the following components:

- Significant Issues – status of previous significant issues if applicable and new significant issues
- Summary of Queries from site survey (if applicable)
- Strengths of the Trauma Program
- Opportunities for Improvement
- Medical Record Review

The Accreditation Report, with the exception of the active significant issues, will not be provided to the Survey Team or the Board for the hospital's next survey.

## Disagreement with Accreditation Determination

Should a hospital disagree with the accreditation determination or significant issue(s) the hospital may send a letter via email to the PTSF Staff Lead for the Board to review. The letter should outline the reason that the determination should be re-considered per PTSF Policy AC-136: Request for Reconsideration of Accreditation Deliberation Decision. If the issue remains unresolved, PTSF Policy AC-103: Appeals Process should be referenced.

## Action Plans

Significant issue(s) assigned in an accreditation report must be addressed within 3 months via an Action Plan. The Trauma Program must complete an Action Plan for each significant issue and submit the plan to the PTSF Staff Lead. The Action Plan due date is assigned within the cover letter of the accreditation report. Submit via email to the PTSF Staff Lead. Action Plans are reviewed by PTSF staff who will provide follow-up to the Trauma Center.

The Action Plan must be submitted on the Action Plan Template, available on the Site Survey page of the PTSF website. Complete the information up to and including the Metrics to Demonstrate Resolution section.

The submission will include the following information for each significant issue:

- Title of Significant Issue – The title of the significant issue from the accreditation report.
- Analysis
    - Summary of the Trauma Program's analysis of the specific significant issue.
    - The conclusions of the analysis will identify the contributing factors or causes that resulted in receiving this significant issue.
    - Do NOT copy and paste the significant issue write-up from the accreditation report.
    - Can be listed or in narrative format.
- Corrective Actions
    - List the corrective actions the Trauma Program plans to implement to address the significant issue.
    - The corrective actions do not have to be completed by submission.
    - If any of the corrective actions have been initiated or completed, you may include the implementation date.
- Metrics to Demonstrate Resolution
    - The overall measurable goal that will indicate to you and future Survey Teams that the significant issue is resolved (percentage rate of expected compliance).
    - The specific metric (i.e., graphs, data, benchmarks, dates) that will be tracked or measured for this significant issue to evaluate if the corrective actions have resolved the significant issue.
    - Each corrective action may correlate with a specific metric that will be measured.

Example of an acceptable Action Plan:

| Title of Significant Issue | Compliance with Advanced Trauma Life Support Principles |
|---|---|
| Analysis | A retrospective review to identify patterns in ATLS deviations was completed. Custom elements relevant to ATLS principles were added to Collector and a registry report was created to complete this retrospective analysis and determine a baseline.<br>1. Identified variation amongst all providers in compliance with ATLS, though not specific to 1 provider. The factor contributing to this is the Resuscitative Policy that provides minimal guidance and does not comprehensively standardize care.<br>2. Identified a delay or lack of obtaining chest or pelvis x-rays in Trauma Activation patients. Radiology Techs shared that they typically wait outside the resuscitation room for someone to let them know if/when an x-ray is needed. The trauma activation leaders shared that the delay/lack of obtaining was related to x-ray not being available. We determined that the trauma activation leader did not know the Radiology Tech was waiting outside the room. We recognized this is a process we must work on.<br>a. Average time to portable chest x-ray = 20 min.<br>b. Percent of patients without portable chest x-ray = 20%<br>c. Average time to portable pelvis x-ray = 32 min.<br>3. Identified hemodynamically unstable patients going to CT scan. Nurses shared that they were not aware that hemodynamically patients should not go to CT scan. The trauma activation leaders shared that they felt comfortable transporting the patient because they traveled with the patient and the patient had responded to fluids. We recognized this is a process we must work on.<br>a. Percent of hemodynamically unstable patients that went to CT scan = 25%<br>4. Identified use of excessive crystalloids prior to administering blood in hemodynamically unstable patients. Identified delay in obtaining blood products from the blood bank. Nurses shared that they were not aware that crystalloids should be limited, and that timely blood administration is preferred. The trauma team leader was not aware of the amount of crystalloids patients received prior to blood administration. We recognized this is a process we must work on.<br>a. Average amount of crystalloids prior to blood = 3500 L<br>b. Average time from identifying SBP <90 to first blood administered = 27 min |
| Corrective Actions | 1. Host biannual combined ATLS and ATCN courses.<br>a. Require all physician, AP and ED nurse Trauma activation responders attend.<br>2. Purchase a blood refrigerator to be housed near the resuscitation rooms to decrease the amount of time to blood administration.<br>a. Developed a new policy that addresses the use of blood from the blood refrigerator<br>b. Education on the new policy and procedure for using |

| | |
|---|---|
| | blood from the blood refrigerator to all ED physicians, nurses and APs, Trauma Service, Blood Bank, OR, etc.<br>3. Revise the Resuscitative Policy (with the help of the key stakeholders Trauma Program, Trauma Service, EM, ED Nursing, Radiology, etc.) to be more comprehensive and include each step in ATLS and indications for points of decision making<br>a. Empower the Radiology Techs to automatically enter the resuscitation room to obtain a portable chest x-ray in trauma activation patients without waiting for physician direction<br>b. Empower nurses to speak up if the Resuscitative Policy is not being followed<br>c. Education on the new policy to all ED physicians, nurses and APs, Trauma Service, Radiology Techs, Blood Bank, OR, etc.<br>d. Availability of a laminated copy of the Resuscitative Policy<br>4. Create a Flowchart based on the revised Resuscitative Policy for utilization in the resuscitation area<br>a. Education of the flowchart to all ED physicians, nurses and APs, Trauma Service, Radiology Techs, Blood Bank, OR, etc.<br>b. Place a large, laminated copy of the Flowchart on the wall of each resuscitation room with dry erase markers available for providers to write on it<br>5. Develop standing orders for Trauma Activations<br>a. Education on the standing orders to all ED physicians, nurses and APs, Trauma Service, Radiology Techs, etc.<br>6. Initiate weekly mock trauma activations with subsequent debrief<br>7. Develop and share a trauma activation scorecard that is distributed to each person that responded to the activation |
| Metrics to Demonstrate Resolution | 1. Goal average time to portable chest x-ray ≤10 min.<br>2. Goal percent of patients without portable chest x-ray ≤2 %<br>3. Goal average time to portable pelvis x-ray ≤10 min.<br>4. Goal percent of hemodynamically unstable patients that went to CT scan = 0%<br>5. Goal average amount of crystalloids prior to blood ≤2 L<br>6. Goal average time from identifying SBP <90 to first blood administered ≤5 min |

## Action Plan Progress Reports

In addition to the initial Action Plan submission, the Trauma Program may have to submit follow-up progress report(s) within the accreditation period (typically one or two years) if a significant issue is unresolved or the PTSF Board requests a Progress Report. If this is required, it will be listed with an assigned submission date within the cover letter or body of the accreditation report. The intention of the progress report is to assure that the Trauma Program continues to address significant issue(s). The follow-up report should demonstrate the program's progress towards resolution of the significant issue(s) which would be demonstrated in the data. Utilize the same Action Plan document submitted to PTSF. The Analysis, Corrective Actions, and Metrics to Demonstrate Resolution do not require updates. Complete the Re-evaluation Phase section on the template. Submit via email to the PTSF Staff Lead. This report will be redacted and presented to the PTSF Board for review. The PTSF will notify the Trauma Center of the results including any additional requests if applicable.

The new submission will include:

- Re-evaluation Phase
    - Address each item listed in the previously submitted Metrics to Demonstrate Resolution.
    - Re-evaluate the current state of the significant issue and list the results/data from the re-evaluation.
    - Specify demonstrated Trauma Program has demonstrated resolution or if progress towards resolution.
    - If your Trauma Program determined that the previously implemented corrective actions are not providing the desired results and your Trauma Program implemented or plans to implement additional new corrective actions, you may list the actions here.

Example of an acceptable Action Plan Progress Report:

| | |
|---|---|
| Re-Evaluation | 1. Average time to portable chest x-ray = 13.5 min.<br>2. Percent of patients without portable chest x-ray = 5%<br>3. Average time to portable pelvis x-ray = 16 min.<br>4. Percent of hemodynamically unstable patients that went to CT scan = 4%<br>5. Average amount of crystalloids prior to blood = 2500 mL<br>6. Average time from identifying SBP <90 to first blood administered = 15 min |

# APPENDIX

The information contained in this section are intended to help in a hospital's preparation for site survey. If you have any questions, please contact the PTSF office.

A. Physician Group Meeting Potential Questions
B. Nursing & Collaborative Services Group Meeting Potential Questions
C. Survey Day Participants
D. Survey Day Staff Interview Contact List
E. Information to Have Available for Surveyor Review

# Physician Group Meeting

## POTENTIAL QUESTIONS

Listed below are some questions that Surveyors have asked on previous surveys during Group Meetings; it is not guaranteed that they will ask these exact questions. Often the Surveyor will give the group a case scenario and ask each attendee to describe their role in the care of the trauma patient based on specialty. This includes interaction with pre-hospital personnel and care from the emergency department through the course of hospitalization to rehabilitation. Make sure the attendees know what kinds of questions may be asked so that they can be prepared to answer. The Trauma Program Medical Director should avoid answering questions.

- When EMS has a trauma patient, how is it communicated to the ED? Can EMS call trauma activations?
- Describe the relationship between your hospital and EMS agencies. For example, how is PI information regarding Prehospital care shared with EMS?
- Describe a recent clinical issue that required additional education for a specific EMS agency/provider.
- Describe how a trauma patient enters your system and who makes triage decisions.
- Who responds to trauma activations? Who manages the trauma patient's airway?
- What is the working relationship between Emergency Medicine, Residents, Anesthesia, CRNAs and the Trauma Service?
- If a patient must go to the OR/IR, how is that communicated to that department? What is the response expectation, specifically for emergent cases?
- How has trauma clinical practice in your specialty changed since the last site survey?
- Describe any major changes (equipment/personnel/responsibilities related to trauma patient care) within your specific department and/or clinical area?
- Describe your subspecialty service's relationship with the Trauma Service.
- Identify a PI issue specific to your specialty service and discuss what your specialty service did to assure the issue was resolved.
- Is the TQIP report shared with you? Are you aware of your specialty's indicators on the TQIP report?
- Describe the development of a clinical treatment plan for a specific type of trauma patient, for example, a spinal cord injured patient and the working relationship between the Trauma Service, Neurosurgery, Orthopedics and Rehabilitation?
- Describe a Practice Management Guideline. For example, if the patient has an open fracture, how is the patient managed?

- What type of injuries does your specialty service manage versus transfer out?

- Describe the decision to transfer a severely injured trauma patient (pediatric, obstetric, complex pelvic fracture, spinal cord injury, etc.).
    - Who makes the decision and what clinical criteria are utilized?
    - What are the roles of the Trauma Surgeon, Emergency Medicine, and/or Pediatrician?

- How do the following specialties interact in the care of trauma patients?

- Who manages the patient in the ICU? For example:
    - Who manages a trauma patient on a ventilator?
    - What is the role of the ICU service?
    - Who is the first responder to the ICU and what clinical scenarios require the physical presence of an attending trauma surgeon?
    - If a trauma patient has an elevated ICP, who is the first person to receive a phone call (First responder, trauma resident, attending trauma surgeon, neurosurgical resident, and/or the attending neurosurgeon) and how is the patient managed?

- Describe the criteria for determining which patients receive rehab (PT, OT, Speech) consults. Who makes this determination?

- Describe use of Advanced Practitioners and Residents in care of the trauma patient.

# Nursing & Collaborative Services Group Meeting

## POTENTIAL QUESTIONS

Listed below are some questions that Surveyors have asked on previous surveys during Group Meetings; it is not guaranteed that they will ask these exact questions. Remember, specific questions are directed toward various representatives of the Trauma Center. Often the Surveyor will present a case scenario during which each attendee involved with the patient throughout the continuum of care is asked to discuss their involvement. Make sure the attendees know what kinds of questions may be asked so that they can be prepared to answer. The Trauma Program Manager should avoid answering questions.

Due to time constraints, ensure that the representatives that you select are key front-line staff and/or managers that interact with staff and patients.

- When EMS has a trauma patient, how is it communicated to the ED? Can EMS call trauma activations?
- Describe how a trauma patient enters your system and who makes triage decisions.
- How many nurses are available in the ED for a trauma patient during a shift?
- How does the CT technician know a trauma activation patient is going to CT scan? If there is a simultaneous stroke and trauma patient, who has priority?
- If a patient must go to the OR/IR, how is that communicated to that department?
- How is an OR room made available to a trauma activation patient who needs emergent operative intervention? Is an OR room always open for trauma?
- Describe the availability of the OR team on the off shifts. Are they in-house 24/7? How many back-up teams? How many times has the back-up team been called in over the past year?
- How has your clinical area/unit changed since the last site survey? For example, equipment, personnel, responsibilities related to trauma patient care, etc.
- What trauma education do staff receive to prepare to care for trauma patients? What continuing trauma education do staff receive?
- How are issues/events communicated to the Trauma Program? If you identify a trauma related PI issue/event, who do you contact at the Trauma Program?
- What trauma related PI projects are you working on in your department/clinical area/unit? Why were they chosen? Who collects/communicates this information? How is it tracked/trended and communicated to the Trauma Service as well as the rest of the hospital? Be prepared to state the data.
- Describe the last “major” clinical and/or system issue that affected trauma patient care in your specific department/clinical area/unit.

- Describe the case management system and/or the coordination of clinical care, discharge planning, and follow-up care.

- What is case management/social work availability? For example, are they available 7 days a week?

- What is the SBIRT process? Who is responsible for screenings and who is responsible for interventions?

- When a rehabilitation service (PT, OT, Speech) consult is placed, how long does the service have to complete the consult? What is the weekend coverage for the service?

- What is PT, OT, and Speech availability? For example, are they available 7 days a week?

- If a trauma patient deteriorates, who do you contact (Trauma AP, trauma resident, attending trauma surgeon)? For example, if the patient has an elevated ICP, who is contacted first, the Trauma Service or Neurosurgery Service?

# Survey Day Participants

(Trauma Program Use Only, Do Not Send to PTSF)

Listed below are the survey day participants. ✓ indicates required; R indicates recommended.

| Level I-III | Opening | Physician Group Meeting | Nursing & Collaborative Services Group Meeting | Significant Issue & PI Overview | Medical Record Review | Leadership Closing Meeting |
|---|---|---|---|---|---|---|
| Trauma Program Medical Director | ✓ | ✓ | | ✓ | ✓ | ✓ |
| Trauma Program Manager | ✓ | | ✓ | ✓ | ✓ | ✓ |
| Trauma Program PI Nurse | R | | ✓ | ✓ | ✓ | ✓ |
| Registrar | R | | | R | R | R |
| Hospital Board Member | R | | | | | |
| Hospital Administration Representative (i.e., CEO/President) | ✓ | ✓ | | | | ✓ |
| Nursing Administration Representative | R | | ✓ | | | R |
| Emergency Medicine Liaison or Chief | R | ✓ | | | | R |
| Radiologist Liaison or Chief | | ✓ | | | | |
| Orthopedic Surgery Liaison or Chief | | ✓ | | | | |
| Anesthesia Liaison or Chief | | ✓ | | | | |
| Neurosurgery Liaison or Chief | | ✓ | | | | |
| Director and/or Co-Director of the ICU | | ✓ | | | | |
| Physician Responsible for Trauma Rehabilitation | | R | | | | |
| EMS Representative | | R | | | | |
| Pediatric Liaison or Chief | | R | | | | |
| Trauma Advanced Practitioner | | R | | | | |
| Trauma Surgeon | | R | | | | |
| Emergency Department Nurse Manager | | | ✓ | | | |
| Trauma and/or Surgical ICU Nurse Manager | | | ✓ | | | |
| Operative and/or Perioperative Nurse Manager | | | ✓ | | | |
| Medical-Surgical Nurse Manager | | | ✓ | | | |
| Nurse Educator | | | ✓ | | | |
| Case Manager | | | R | | | |
| Social Services/Social Work/Chaplain | | | R | | | |
| Trauma Rehabilitation Services Manager (PT/OT/Speech) | | | R | | | |
| Injury Prevention Coordinator | | | R | | | |
| Step-Down Nurse Manager | | | R | | | |
| Pediatric Nurse Manager | | | R | | | |

| Level IV | Opening | Physician, Nursing & Collaborative Services Group Meeting | Significant Issue & PI Overview | Medical Record Review | Leadership Closing Meeting |
|---|---|---|---|---|---|
| Trauma Program Medical Director | ✓ | ✓ | ✓ | ✓ | ✓ |
| Trauma Program Manager | ✓ | ✓ | ✓ | ✓ | ✓ |
| Trauma Program PI Nurse | R | ✓ | ✓ | ✓ | ✓ |
| Registrar | R | | R | R | R |
| Hospital Board Member | R | | | | |
| Hospital Administration Representative (i.e., CEO/President) | ✓ | ✓ | | | ✓ |
| Nursing Administration Representative | R | ✓ | | | R |
| Emergency Medicine Liaison or Chief | R | ✓ | | | R |
| Emergency Department Nurse Manager | | ✓ | | | |
| Radiologist Liaison or Chief | | ✓ | | | |
| Orthopedic Surgery Liaison or Chief | | ✓, if applicable | | | |
| Anesthesia Liaison or Chief | | ✓, if applicable | | | |
| Neurosurgery Liaison or Chief | | ✓, if applicable | | | |
| Director and/or Co-Director of the ICU | | ✓, if applicable | | | |
| Trauma/Surgical ICU Nurse Manager | | ✓, if applicable | | | |
| Operative and/or Perioperative Nurse Manager | | ✓, if applicable | | | |
| Step-Down Unit Nurse Manager | | ✓, if applicable | | | |
| Medical-Surgical Nurse Manager | | ✓, if applicable | | | |
| Nurse Educator | | ✓, if applicable | | | |
| EMS Representative | | R | | | |
| Case Manager/Social Worker | | R | | | |
| Trauma Rehabilitation Services Manager (PT/OT/Speech) | | R | | | |
| Mentoring Hospital Representative | R | | R | R | R |

# Survey Day Staff Interview Contact List

(Trauma Program Use Only, Do Not Send to PTSF)

Use this list as a handy reference for administration/staff members that the Surveyors may wish to contact on the survey day (as applicable).

| Title | Date Notified | Name | Survey Day Contact Phone Number |
|---|---|---|---|
| Hospital Board Member | | | |
| Hospital Administration | | | |
| Chief Executive Officer | | | |
| Trauma Administrator | | | |
| Medical Staff | | | |
| Chief of Anesthesiology | | | |
| Director of Emergency Medicine | | | |
| Director of Surgical/Medical ICU | | | |
| Chief of Neurosurgery | | | |
| Chief of Orthopedic Surgery | | | |
| Chief of Surgery | | | |
| Chief Surgical Resident | | | |
| Chief of Radiology | | | |
| Fellow, Resident, or Advanced Practitioner from any trauma-related specialty | | | |
| Nursing Administration | | | |
| Chief Nursing Officer, Vice President of Nursing or Director of Nursing | | | |
| Manager of Emergency Department | | | |
| Manager of Intensive Care Unit | | | |
| Manager of Step-Down Unit | | | |
| Manager of Operating Room | | | |
| Manager of Post-Anesthesia Care Unit | | | |
| Manager of Trauma Medical/Surgical Units | | | |
| Manager of Rehabilitation | | | |
| Staff Nurse from any trauma unit | | | |

| Title | Date Notified | Name | Survey Day Contact Phone Number |
|---|---|---|---|
| Support Services | | | |
| Director of Medical Records | | | |
| Trauma Registrar | | | |
| CT/X-ray Technologist | | | |
| Trauma Case Manager | | | |
| Trauma Educator | | | |
| Director of Quality | | | |
| Director of Laboratory | | | |
| Director of Blood Bank | | | |
| Social Work | | | |
| Pre-hospital Coordinator | | | |
| Pastoral Care | | | |
| Other | | | |
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# Information to Have Available for Survey Team Review

(Trauma Program Use Only, Do Not Send to PTSF)

| ITEM(S) | COMMENTS |
|---|---|
| **Medical Records Selected**<br><br>☐ Arrange Medical Records in chronological trauma number order (i.e., 20220001, 20220012, 20220033, etc.)<br><br>☐ If not available in the electronic medical record, please have the following available upon request with the PI folder<br>o Trauma Flowsheet<br>o EMS patient care records<br>o Autopsy Reports<br>o Follow-up letters/reports | |
| **Performance Improvement**<br><br>☐ ALL patient-specific PI information available for Surveyor review in an electronic or paper folder. Include:<br>☐ Pa V5 Outcomes documentation, Survey Summary Printout is preferred<br>☐ Evidence of patient specific PI communication<br>☐ Evidence of Corrective Actions<br>☐ Evidence of Resolution, such as documents/data supporting loop closure<br>☐ EMS, Transfer and/or Referral follow-up letters<br>☐ Other documents supporting PI activities for the patient<br><br>☐ System PI activities should be available, including meeting minutes, PI initiatives, PI education material etc. Electronic is acceptable.<br><br>**NOTE: Do not print out the Collector case facsimile with the registry information.**<br><br>**NOTE: IF PI is electronic, PTSF Staff must have access to the files (pdf).** | |

| | |
|---|---|
| Each Surveyor's Folder<br>☐ Agenda of the day<br>☐ Name and title of attendees at each session of the survey<br>☐ All Presentations used throughout the day (maximum of 2 slides per page, may be printed in black and white, on both sides)<br>☐ Other information of interest (i.e., hospital newsletters, Trauma Center timeline for program implementation, etc.).<br>☐ Policy noting criteria for trauma alert activation<br><br>Display posters, awards, newsletters around the perimeter of the opening presentation room. These items may be moved into the Medical Records Review Room. | |
| Provide a folder for each PTSF staff with<br>☐ Agenda of the day<br>☐ Name and title of attendees at each session of the survey<br>☐ All Presentations used throughout the day (maximum of 2 slides per page, may be printed in black and white, on both sides)<br>☐ Other information of interest (i.e., hospital newsletters, Trauma Center timeline for program implementation, etc.).<br>☐ Policy noting criteria for trauma alert activation<br>☐ Documents requested in the AFS Clarification Form such as Completed Education & Credentialing Report and/or PI attendance logs | |
| The following must be accessible – may be in electronic format<br>☐ Trauma Program Policies<br>☐ Trauma Patient Management Guidelines / Practice Management Guidelines/ Clinical Management Guidelines<br>☐ Call schedules for trauma surgeons and subspecialists<br>☐ PI Dashboard<br>☐ TQIP Reports from the survey cycle | |