Site Surveyor Orientation Guide
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 ACS-COT 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.

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,

Amy Krichten MSN, RN, CEN, TCRN
Director of Accreditation
E-Mail: akrichten@ptsf.org
Work: (717) 697-5512, Ext. 103
Cell phone: (717) 577-6138

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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 fashion and provides a forum for any questions to be answered.

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

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

Amy Krichten       (717) 577-6138
Dave Bradley        (717) 304-8141
Kevin Burd                   (717) 576-6194

During the orientation the following information will be reviewed:

- 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), and Significant Issues
- The Site Survey Software computer program and process for medical record review

NOTE: PTSF staff members is not permitted to 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 return.

Assistance/Contacts:

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:

Amy Krichten  
717/697-5512, ext. 103
717/577-6138 (mobile)

Kevin Burd  
717/697-5512, ext. 104
717/576-6194 (mobile)
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:

- **Itinerary**: This will be updated from the one received in your earlier mailing.
- **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.
- **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.
- **Queries**: The PTSF Board of Directors has established some standard queries that will be assigned to each surveyor prior to site survey day.

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 (aka Mock Survey) 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.

Note: Please see the Site Surveyor Guide to the eAFS for additional information.

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.

## Typical Level 1-3 Time Schedule

<table>
<thead>
<tr>
<th>Time</th>
<th>Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>6:45 a.m. to 7 a.m.</td>
<td>Survey Team Arrival &amp; Brief Introductions</td>
</tr>
<tr>
<td>7 a.m. to 7:15 a.m.</td>
<td>Opening Conference by Trauma Center Staff</td>
</tr>
<tr>
<td></td>
<td>*PTSF Staff will open and introduce the survey team</td>
</tr>
<tr>
<td>7:15 a.m. to 8 a.m.</td>
<td>Physician Group Meeting</td>
</tr>
<tr>
<td></td>
<td>Nursing/Ancillary Staff Group Meeting</td>
</tr>
<tr>
<td>8 a.m. to 8:45 a.m.</td>
<td>Significant Issue (n/a for new applicants) / Performance Improvement Review</td>
</tr>
<tr>
<td>8:45 a.m. to 9:15 a.m.</td>
<td>Hospital Tour</td>
</tr>
<tr>
<td>9:15 a.m. to Noon</td>
<td>Medical Record Review</td>
</tr>
<tr>
<td>Noon to 12:45 p.m.</td>
<td>Lunch (Private)</td>
</tr>
<tr>
<td>12:45 p.m. to 4 p.m.</td>
<td>Medical Record Review Continues</td>
</tr>
<tr>
<td></td>
<td>(Requested queries will be reviewed by the surveyor during this time.)</td>
</tr>
<tr>
<td>4 p.m. to 5:30 p.m.</td>
<td>Private survey team group meeting/discussion time</td>
</tr>
<tr>
<td>5:30 p.m. to 6 p.m.</td>
<td>Leadership Meeting</td>
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</tbody>
</table>

## Typical Level 4 Time Schedule

<table>
<thead>
<tr>
<th>Time</th>
<th>Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>6:45 a.m. to 7</td>
<td>Survey Team Arrival &amp; Brief Introductions</td>
</tr>
<tr>
<td>7:00 a.m. to 7:15 a.m.</td>
<td>Opening Conference by Trauma Center Staff</td>
</tr>
<tr>
<td>7:15 a.m. to 8:00 a.m.</td>
<td>Physician/Nurse/Ancillary Staff Group Meeting</td>
</tr>
<tr>
<td>8:00 a.m. to 8:45 a.m.</td>
<td>Significant Issue (n/a for new applicants) / Performance Improvement Review</td>
</tr>
<tr>
<td>8:45 a.m. to 9:15 a.m.</td>
<td>Hospital Tour</td>
</tr>
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<td>9:15 a.m. to Noon</td>
<td>Medical Record Review</td>
</tr>
<tr>
<td>Noon to 12:30 p.m.</td>
<td>Lunch (Private)</td>
</tr>
<tr>
<td>12:30 p.m. to 3:00 p.m.</td>
<td>Medical Record Review</td>
</tr>
<tr>
<td>3:00 p.m. to 4:00 p.m.</td>
<td>Private survey team group meeting/discussion time</td>
</tr>
<tr>
<td>4:00 p.m. to 4:30 p.m.</td>
<td>Leadership Meeting</td>
</tr>
</tbody>
</table>
**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).
Potential Physical Group Meeting 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 1st 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., 1st 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.
Potential Nursing Group Meeting 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 polices/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.

<table>
<thead>
<tr>
<th>Recommended Tour Route (3 member team)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trauma Surgeon Team Leader</td>
</tr>
<tr>
<td>Trauma Surgeon</td>
</tr>
<tr>
<td>Registered Nurse</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Recommended Tour Route (4 member team)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trauma Surgeon Team Leader</td>
</tr>
<tr>
<td>Trauma Surgeon</td>
</tr>
<tr>
<td>Neurosurgeon, Orthopedic Surgeon or Additional Trauma Surgeon</td>
</tr>
<tr>
<td>Emergency Physician</td>
</tr>
<tr>
<td>Registered Nurse</td>
</tr>
</tbody>
</table>

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.
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 During Entire Day:**

- 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 institution’s 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 institution’s 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 1st 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 response 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 1st (previous year) through date of survey
- **Trauma Center with Provisional Accreditation**: October 1st (previous year) through date of survey
- **Trauma Center with One-Year Accreditation**: October 1st (previous year) through date of survey with focus on January 1st through date of survey (within current year)
- **New Applicant**: January 1st (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
- Head
- Neck Spinal cord
- Chest (including aorta)
- Pelvic
- Major extremity

And a wide range of demographics and dispositions:

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

Rather than: Use:

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.
Site Survey Software

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. Screen shots are accessible on the PTSF web page: www.ptsf.org. Click: Resources, Accreditation (Show): Year/Site Survey Collector Screen Shots by specialty.

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.

Medical Record Review

[Table and data input interface]
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.
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.

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.

The procedure for opening a record in the survey software will be reviewed with you on the day of survey
Saving a Record

The save options are located at the bottom of the trauma record window.

- Select [Save] to save the current trauma record without exiting the record.
- Select [Save/Exit] to save the current trauma record and exit the record.
- Select [Cancel] to exit the record without saving changes. The Confirm Cancel screen will open. Select [OK] to confirm the cancel without saving. Select [Cancel] to remain in the current trauma record.
Validation Checks
The checks process validates the data in the current trauma record. The following types of validation checks exist:

- Blank/Required checks verify if required fields contain data. If a required field does not contain data, user will receive a blank/required check.
- Duplicate checks warn if duplicate values have been entered into a list. If duplicate values are entered into a list, the user will receive a duplicate check.

To perform checks on a record, do the following:

1) Select the [Check] button.

2) The Check Failure screen will open. The Check Failure screen lists all failed checks within the current record.

3) To correct the data, follow these steps:
   a. Select the failed check on the Check Failure screen. To select the failed check, left-click the row using the mouse and highlight the row on the Check Failure screen.
b. Select the [Goto] button. This will return the user to the incorrect field, so the user may correct the data entry errors.

c. Correct the data entry error.

d. Return to the Check Failure screen and select the [Recheck] button. The check is removed once the data correction meets the validation requirements.

e. Users also have the option of validating some data checks. When a user validates a data check, the user reviews the data in the field and approves the quality of the data.

f. To validate a data check, select the failed check on the Check Failure screen. To select the failed check, left-click the row using the mouse and highlight the row on the Check Failure screen. Select the [Validate] button. The Confirm Check Validate screen will open. Select [Yes] to validate the check. Select [No] to not validate the check.

g. Once all check issues are resolved, the Recheck screen will open. Select [OK].

h. Select the [Save] or [Save/Exit] button to save the validated record. The record status will now update from Active to Closed. The closed record status indicates that checks have been performed and validated on the current record.
Process to Access the Electronic Application for Survey

Before accessing the application, the Foundation encourages you to view the 10 minute Site Surveyor EAFS Orientation available under the SUPPORT button after you log in at ptsfafs.org. That orientation will cover the items discussed below.

1. Go to https://www.ptsfafs.org/. 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 APPLICATION FOR SURVEY button
5. The next screen that will display is the **Facility Survey** screen. The Facility Survey screen is where the user can select the Standard they will review. To select a Standard, right click on the Standard and then click the View button in the upper right of your screen.

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.
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.

![View Survey Record](image)

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

![Additional Attachments](image)

Double clicking on the “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. Once in a standard go to the bottom of the screen and click “Print.”
2. When you click “Print” another web page will appear with the standard in a printable format. You may now print the standard in the same manner you would print any webpage. Please note that any attachments associated with this standard will be listed by number, but will not print when using this method.

Printing the Attachment Only

1. Once in a standard, click on the “View” button if it is a question with an attachment or click on the “Additional Attachments” tab.
2. Whether you are in the “Additional Attachments” section or in the Standard click on the “View” button.

3. A View Download box will then appear asking you to Open or Save the pdf file. Clicking on the down arrow next to Save will allow to choose Save as. Save as will allow to choose where on your computer you would like to save to.

6. 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. Once in a standard go to the bottom of the screen and click "Export".

2. Clicking the "Export" button will bring up the View 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".
3. Double clicking on any of the files will open them in their appropriate format. Once open you may print the attachment in the same manner you would any 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 Clarification Form

After a trauma center completes the EAFS, PTSF staff reviews it in its entirety and asks clarifying questions in the **Clarification Form** located in the eAIFS. A deadline of 2 weeks is given for the trauma center to respond to the question(s) either directly in the master form 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 Facility Survey screen will say “Awaiting Correction”.

If you have any questions, please don’t hesitate to contact the PTSF