REVIEW AGENDA AND LOGISTICS

The purpose of the American College of Surgeons Verification, Review, & Consultation (VRC) Program is to verify a hospital's compliance with the ACS standards for a trauma center.

The trauma program personnel at the hospital must carefully prepare for a site visit, as Reviewers must obtain a detailed and accurate assessment of a hospital's capabilities, within a short period of time. Thus, all documents and medical records must be carefully organized and easily accessible, and Wi-Fi/ Internet access should be available, as Reviewers will be working on the VRC Site Visit Report at the time of the site visit.

Additionally, Reviewers may request additional information, clarification and supportive content, besides the indicated documents, before validating compliance with ACS standards.

It would be helpful for the hospital to have the trauma program manager (TPM), trauma registrar, and trauma medical director (TMD) available on-site, during the entire site visit.

The hospital and/or trauma program personnel are responsible for Reviewers hotel and ground transportation; however, if a Reviewer prefers a rental car, they will arrange that through the ACS Travel Agent, for which ACS will cover the cost. This will occasionally happen when there is a tandem visit scheduled (back-to-back) and the two hospitals are far away from each other, or if the airport is significantly far from the hospital. For the most part, the Reviewers prefer to be picked up at the airport since they are not familiar with the area. In such a case, the hospital and/or trauma program personnel would be responsible for receiving the Reviewers and arranging their pick-up/ drop-off to/from the airport.

It is recommended that once the hotel arrangements are made, the TPM forward the hotel confirmations directly to the Reviewers. At this time, the TPM may inquire about their travel plans, arrangements and dietary restrictions.

REVIEW AGENDA

The review process will last approximately six to eight hours, over the two-day site visit period.

Please do not create your own agenda or presentation; instead, please follow the sample agenda provided below:

Sample Agenda		
Day #1	11:00 am – 5:00 pm	Chart review and evaluation of PI
	6:00 pm – 8:30 pm	Pre-review meeting dinner
Day #2	7:00 am – 8:00 am	Hospital tour
	8:00 am – 9:00 am	Additional Assessments - further chart review - evaluation of PI - review of other documentation
	9:00 am – 10:00 am	Review Team Closed Meeting (30-60) minutes
	10:00 am – 12:00 pm	Exit Interview (30-60) minutes
Note: -Depending on the reviewers flights they typically arrive anytime between 11am-1pm the day of the visit or occasionally the night before. -The Lead Reviewer will coordinate the format of the site visit or the hospital tour with the trauma program manager and the Review Team.		

Chart Review/ PIPS

Refer to list beginning on page 6

1. Review performance improvement documents
2. Case Review using medical records
3. Report process

PRE-REVIEW MEETING DINNER

A pre-review meeting dinner is required. However, the dinner portion does not need to a separate component, and can be incorporated into the pre-review meeting.

Recommended Participants at the Pre-review Meeting Dinner

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

HOSPITAL TOUR

Reviewers will determine the specifics of the hospital tour, including the start time. Please arrange a group of trauma team members, who will guide each Reviewer during the tour. Additionally, please ensure that the appropriate department staff will be available to meet with Reviewers during the tour.

The hospital tour will include the following departments:

A. Ambulance Bay

Assessed by all Reviewers

B. Helipad (if onsite)

Assessed by all Reviewers

C. Decontamination/ Mass Casualty

Do not setup decontamination or mass casualty equipment

Assessed by all Reviewers

D. Emergency Department

Assessed by all Reviewers

1. Review emergency department facility, resuscitation area, equipment, protocols, flow sheet, staffing, and trauma call
2. Interview emergency physician, and emergency nurse

Assessed by a specific Reviewer

3. Review the prehospital interaction and performance improvement and patient safety feedback mechanism
4. The emergency department schedule should be available for review. There may be additional documentation requested on-site by the review team.

E. Radiology

Assessed by a specific Reviewer

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

F. Operating Room/PACU

Assessed by a specific Reviewer

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

G. ICU / PICU

Assessed by a specific Reviewer

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

H. Blood Bank

Assessed by a specific Reviewer

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

I. Rehabilitation

Assessed by a specific Reviewer

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

ADDITIONAL ASSESSMENTS:

J. Interviews/Questions for a specific department

May be conducted during the pre-review dinner, or any time prior to the Exit Interview
Interviews include (but are not limited to) the following hospital personnel:

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

REVIEW TEAM CLOSED MEETING

In preparation for the Exit Interview, a Review Team Closed Meeting will be held. No hospital and/or trauma program personnel will be permitted to attend. However, if the designating agency representative is present and available, they may be invited to attend.

Shortly after the Closed Meeting, the Review team will have a debriefing session with the TPM and TMD to present a summary of their findings.

EXIT INTERVIEW

Attendees for Exit Interview may consist of…

1. Hospital administration
2. Trauma medical director
3. Trauma program manager
4. Others as desired by hospital administration

For a copy of the VRC Exit Statement, visit www.facs.org/quality-programs/trauma/vrc/resources

MATERIALS REQUIRED AT TIME OF REVIEW

All indicated materials must be available and organized systematically as noted below where the case review assessment will be conducted. Please note that this room must have adequate space for Reviewers to be comfortable while conducting the case reviews. Please provide a power sources for reviewer's computers.

The required documentation must be organized systematically and labeled in binders (excludes case reviews).

A. Documentation of the hospital's trauma activity for during the reporting period (the time frame used to complete the PRQ)

1. Community Outreach/Injury Prevention
2. Research – protocols, IRB submissions, trauma related manuscripts – published or in press Within the last 3 years.
   - For Level I trauma centers and/or Level I Pediatric Trauma Centers, the **Summary Form for Research** must be completed for each article being considered to meet the requirement, http://www.facs.org/quality-programs/trauma/vrc/resources
   - For Level I trauma centers and/or Level I Pediatric Trauma Centers, the **OTA Fellowship Questionnaire** must be completed and forwarded to the VRC office 30 days prior to the site visit to ensure compliance, http://www.facs.org/quality-programs/trauma/vrc/resources

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

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

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

1. External Education – Trauma Medical Director and liaisons
2. Internal Education Process (IEP) and/or External Education – nonliaisons and TPM
   – For examples of external and internal CME refer to the Resources 2014 Manual at www.facs.org/quality-programs/trauma/vrc/resources.

D. Performance Improvement and Patient Safety (PIPS)

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

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

For programs seeking separate pediatric verification, separate medical records must be available onsite for the pediatric population (less than 15 years of age) for the same categories as the adult.

The trauma registrar may be asked to extract data from the trauma registry upon the site surveyors' request.

The medical records must be pulled for the reporting period and should not be older than 14 months prior to the scheduled survey date.

The following contents must be made available for each medical record category indicated below:

Paper Medical Records

1. Facesheet summary that outlines the following content
2. Prehospital
    a) EMS run sheet w/ISS
    b) Transferring facility ED info
3. Trauma Flow Sheet
4. H&P
5. Consults
6. Op notes
7. Discharge Summaries
8. Autopsy reports, if available
9. Copies of PI documentation and other related information, if applicable

Electronic Medical Records (EMR), for each Reviewer, there must be a computer and a staff member assigned who is proficient and able to navigate the EMR software. The EMR software **must** be easily accessible and/or tabulated to display the following:

1. Prehospital
    a) EMS run sheet w/ISS
    b) Transferring facility ED info
2. Trauma Flow Sheet
3. H&P
4. Consults
5. Op notes
6. Discharge Summaries
7. Autopsy reports, if available
8. Copies of PI documentation and other related information, if applicable

Important: Please contact the Lead Reviewer to determine which of the following is preferred during the site visit:

1. Medical records entirely printed, or
2. If EMR, does the reviewer require any additional information printed]for the site visit

If in any of the following medical record categories, the minimum cannot be met for the reporting year, medical records outside the reporting period may be included if it impacted the center's performance improvement*.

With regard to the trauma deaths and based on the center's Mortality conference:

- Adult Center only – Pull at minimum 30 charts
- Peds Center only– Pull 20 charts
- Combined adults & peds center– Pull 30 adult & 20 peds charts
- Adult Program that treats peds too – Pull 30 charts (pull mixture of both)

Separate and label into the following categories:

1. Mortality without opportunity for improvement
2. Mortality with opportunity for improvement
3. Unanticipated mortality with opportunity for improvement

Adult Population Medical Records – Deaths (30 cases): All deaths with opportunities for improvement in the reporting year and the last ten deaths deemed anticipated mortality without opportunity for improvement. At least one patient transferred to hospice should be included if applicable.

Adult Population Medical Records – the last 10 (at minimum) medical records for each of the following categories: If there are not ten patients in each category, then include patients that underwent PIPS.

1. ISS > 25 W/SURVIVAL
2. Pediatric patients < 15 years (only for adult centers treating children)
3. Epidural/subdural hematoma admitted to the ICU
4. Thoracic/cardiac injuries with an AIS code of 3 or greater (include aortic injuries)
5. Severe TBI (GCS< or = 8 in the ED and admitted to the ICU)
6. Spleen and liver injuries: Grade III or higher and requiring surgery, embolization, or transfusion.
7. Pelvis/femur fractures;
    a. Include unstable pelvic fractures with hypotension requiring embolization, surgery, Resuscitative endovascular balloon occlusion of the aorta (REBOA), or transfusion
    b. Open femur fractures
    c. Exclude isolated hip fractures from ground level falls
8. Transfer out for the management of acute injury;
9. Adverse event/death in the SICU or unexpected return to the SICU -or- OR
10. Trauma patients admitted to non-surgical services with ISS > 9

    It is possible that some medical records overlap into other categories. Do not copy the medical record, but instead place the initial medical record in the category deemed appropriate.

Pediatric Population Medical Records <15 years of age **-** Deaths (last 20 charts) All deaths with opportunities for improvement in the reporting year and the last ten deaths deemed anticipated mortality without opportunity for improvement. At least one patient transferred to hospice should be included if applicable.

The last 10 (at minimum) medical records for each of the following categories:

1. ISS > 25 W/SURVIVAL
2. Epidural/subdural hematoma admitted to PICU;
3. Severe TBI (GCS</=8 in the ED or admitted to PICU/ICU)
4. Thoracic/cardiac injuries with an AIS code of 3 or greater (include aortic injuries);
5. Pelvis/femur fractures:
    a. Unstable pelvic fractures/pelvic fractures that go to OR, embolization, or transfusion
    b. Open femur fractures
6. Spleen and liver injuries; (grade III or higher) or with intervention
7. Unexpected return to the OR or PICU
8. Non-accidental trauma (suspected and/or confirmed) with an ISS > 9
9. Trauma patients admitted to non-surgical services with ISS > 9
10. Transfer out for the management of acute injury;

    It is possible that some medical records overlap into other categories. Do not copy the medical record, however place the initial medical record in the category deemed appropriate.

F. Risk-Adjusted Benchmarking Program

All trauma centers must use a risk-adjusted benchmarking system to measure performance and outcomes (CD 15-5). This program should be the ACS-COT Trauma Quality Improvement Program (TQIP). **As of January 1, 2017 all centers must be enrolled in TQIP.**

REPORT STRUCTURE

The report process is the same for all types of visits.

Stage	Phase I	Phase II	Phase II	Phase IV	Phase V	Final
Process	Report submitted by Review Team	Office Receipt	Editorial Review	VRC Vetting	Chair Ruling	Letter/Report Release to Hospital
Anticipated Times	10 working days after initial site visit	Times vary				12-16 weeks after initial site visit