TEXAS Health and Human Services | Texas Department of State Health Services

Texas Trauma Designation Survey Guidelines
September 1, 2025

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Welcome to the Training

Thank to everyone who contributed to this process. All public comments and feedback helped align the survey guidelines with the Texas Administrative Code (TAC) 157.126 and follow the American College of Surgeons (ACS) standards and processes when possible.

We express our gratitude to everyone:

- Stakeholders
- Designation Team
- Rebecca Wright, Adrienne Kitchen, Deidra Lee
- Jia Benno and the State Registry Team
- DSHS Leadership
- Dr. Alan Tyroch, Dr. Stephen Flaherty, and Dr. Robert Greenberg
- Dr. Kate Remick, Sam Vance, and the Pediatric Committee
- Courtney Edwards, DNP, and TETAF

Your participation made a difference!

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Trauma Designation Survey Guidelines

- The goals of the trauma designation survey guidelines are to establish a standardized structure and processes for the designation surveys in Texas. The primary objective is to establish consistency in the trauma surveys regardless of who is performing the survey.
- The secondary objective is to assist the facility administrators, trauma program leaders, and staff in planning and preparing for their trauma designation survey.
- The guidelines outline the expectations for department-approved survey organizations regarding establishing consistency in their processes of selecting, training, and organizing their surveyors and their survey processes.
- The guidelines define the role and responsibilities of the surveyors completing the trauma designation surveys to provide clarity and define consistent expectations in the survey processes.

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Trauma Designation Survey Guidelines

The purpose of the trauma designation survey is to validate the trauma designation requirements in §157.126 are met, and when applicable the ACS verification standards are met. Facilities pursuing designation must demonstrate that all requirements and standards for designation are met.

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Department Surveyor Training Objectives

- Review the authority, responsibility, and operations of DSHS.
- Understand the survey team roles and expectations.
- Demonstrate an understanding of the expectations for a completed survey.
- Identify the standard expectations for the survey process.
- Validate all designation requirements are met.
- Identify strategies to ensure the written survey summary report is completed within the 30-day expectation.
- Evaluate time management skills for completing the review of 10 medical records.

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Trauma Designation Survey Guidelines

TAC 157.126 (p) Trauma facilities seeking designation or redesignation and department-approved survey organizations must follow the department survey guidelines and ensure all surveyors follow these guidelines.

7

Specific Facility Survey Scheduling

- Address potential or actual conflict of interest TAC 157.126
- RAC or contiguous RAC
- System facility
- Assistance in the past 4 years
- Surveyor in the past 4 years
- Facility as well as surveyors
- Level I and II reviewed by surveyors from out of state

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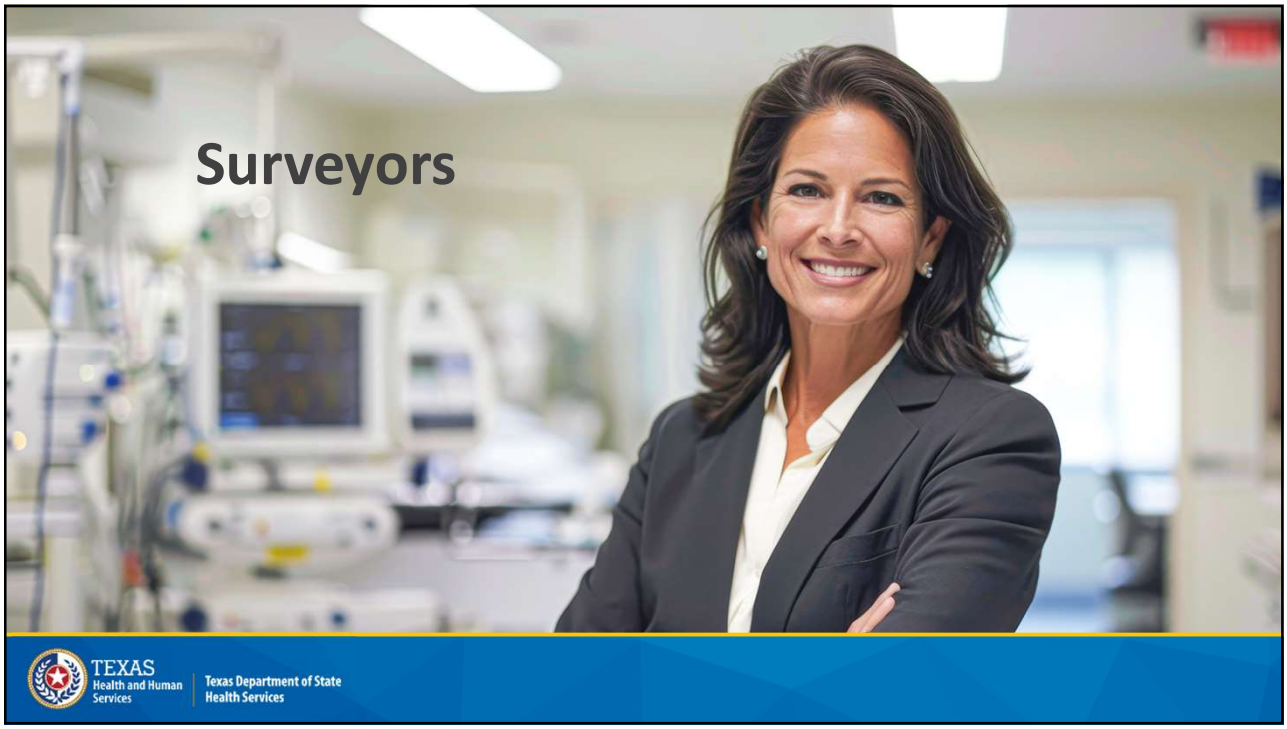

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Strong Surveyors

- Ask clarifying questions
- Engage with facility's staff to address any unclear patient care practices
- Clarify the facility's management guideline(s)
- Review all essential information related to the medical record review
  - Review all associated PIPS documents
- Always maintain professionalism
- Knowledgeable of TAC 157.126 and ACS standards

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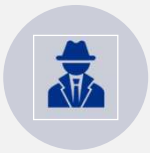
Surveyors Should Avoid

Disclosing information about the survey of a facility

Discussing the facilities you have surveyed

Making unnecessary comments, rendering personal opinions, or statements like “this is how we do it”



Subjective information (e.g., look for facts, evidence)

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Surveyor Expectations

Experience in leading a facility through two successful designation surveys (surveys resulting in a contingent or probationary designation do not meet this requirement)

Lead physician acts as medical director or trauma surgeon, is board certified, actively participates in clinical care in their trauma program and PIPS process

Other physician surveyors must be active as trauma liaisons and participate in their facility’s trauma PIPS program

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Surveyor Requirements

Nurse Surveyors	TPMs who are actively participating in the clinical care oversight of their trauma program
Out of State Surveyors	Surveyors outside of Texas must be from the same or higher level of verified/designated facility. Their facility must have had two successful verification/designation surveys
Emergency Medicine Physicians	Must have a minimum of five years of experience in the role of a program liaison, actively participate in the designated program, and be board certified

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Surveyor Requirements

- Surgeons and nurse surveyors must have completed a PIPS course in the last 4 years and not received any weaknesses or requirements not met related to PIPS in their facility's last site survey
- In-state surveyors must participate in the GETAC process
- Must complete a minimum of two surveys annually
- Must maintain confidentiality with any assigned surveys, prior to the survey and after the survey, and not disclose they surveyed that specific facility or discuss any findings specific to a facility unless it is related to the survey organization's PI process

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Surveyor Requirements

Must complete site surveyor training

Approved survey organization
Department training

All current trauma surveyors approved for trauma surveys must follow the department survey guidelines

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Surveyor Requirements

Level I, II, III, and Level IV managing 101 or more patients meeting the NTDB registry inclusion criteria

Surveyors currently employed by a designated trauma facility at the same or higher level of facility as being surveyed

Surveyors are TMDs, trauma surgeons, trauma liaisons, TPM/directors with current trauma nursing credentials (ENPC or PALS, ATCN or TNCC)

Completed a trauma performance improvement course

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Level IV Managing 100 or Less

Surveyors currently employed in a designated program at the same or higher level of designation

Or surveyor has five or more years of experience in oversight of a trauma program and is current with trauma education and certifications and maintains eight hours of CNE annually

Physicians who have five years of experience in oversight of a trauma program and continue to be employed in a hospital are required to be board certified

Physicians who have five years of oversight of a trauma program must maintain current board certification, ATLS verification, with eight hours of CME annually if not employed in a hospital

Completed a trauma performance improvement course

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Surveyors Hired by Survey Organizations

Must have ten years of experience with oversight of a trauma program

Physicians must maintain board certification and required certifications

Registered Nurses must maintain certifications (TNCC or ATCN, ENPC or PALS)

Maintain eight hours of CME/CNE annually

Evidence of completing trauma performance improvement course

Survey same level of facility they provided oversight and lower level of facilities

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Surveyor Scheduling

- Focus surveys – contingent designation
- Re-review – probationary designation
- Require new surveyors

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Department Surveyor Training Module

Aligns with 157.126

After September 1, 2025

Complete the survey organizations update/training

Address Conflict of Interest outlined in 157.126

Each survey they are assigned

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New Trauma Surveyors

- Attend surveyor organization training
- Attend department training
- Monitor a survey with assigned mentor
  - Review a minimum of three medical records
  - Review medical record summaries with mentor
- Participate in series of surveyor questions
- Surveyor Mentor completes a written critique of the surveyor in training
- Documents are retained by survey organization

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Surveyor in Training

Mentor signs-off, surveyor expectations are met

New surveyor serves on survey team

Physicians mentor physicians

Nurses mentor nurses

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Assigned Survey

Determine if there are any conflicts

Surveyors cannot return to a facility until four years later

Contingent and probationary designation focus or re-reviews require new surveyors to ensure objective review

Once you agree to complete the survey, begin to plan for the survey

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Survey Planning

VIRTUAL OR IN-PERSON

TRAVEL

COMMITMENTS

PRIVACY AND CONFIDENTIALITY

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Survey Planning

- Survey documents
- Loaded into file 45 days prior to the survey
- DAQ, all documents, and self-assessment
- Trauma management guidelines
- Trauma PIPS plan
- Registry Data Quality Plan
- Job descriptions
- Prepare for the conference call 20 days prior to the survey
- Select medical records

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Texas Trauma Facility Designation Assessment Questionnaire Level III

Instructions

This questionnaire contains the pre-survey assessment questions associated with 2022 A Standards and the Texas Administrative Code Chapter 157, §157.126, concerning Trauma Designation Requirements.

If you have questions regarding the completion of the questionnaire, please contact EMS Systems Section's designation staff at DSHS.EMS-TRAUMA@dshs.texas.gov.

When you attach a document, label the file name as *"Attachment #", using the question number to identify the document.*

Example:
1. Attach a copy of the Hospital Board's Resolution defining the commitment to support t

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Attachment 1

2. Summarize the organization and structure of the trauma service approved by the governing body in the medical staff bylaws or rules and regulations. (§157.126(h)(19)).

a. Attach a copy of the trauma operational plan.
Attachment 2a

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3. Attach documentation of the medical staff's process for credentialing a providers. This process covers the Trauma Medical Director (TMD) ove involved in trauma call coverage, the trauma panel, and trauma mana phases of care (§157.126(h)(19)).
Attachment 3

Program Scope and Governance

4. Describe the facility's participation in regional system development.

5. Attach documentation showing Regional Advisory Committee (RAC) pa are met through the designation cycle.

28

na Program Manager Requirements

ide the name and credentials of the Trauma Program Manager (TPM) (who must be a stered nurse).

Attach the TPM job description. TPM is a full-time employee (FTE) dedicated to one facility.
Attachment 15a

Attach the TPM's completed course certificates and any continuing nursing education certificates for the designation cycle. Include the certificates specific to the completion of the trauma performance improvement course and the following certifications: TNCC or ATCN, ENPC or PALS, ACLS, and AAAM (§157.126(h)(21).
Attachment 15b

Attach the TPM's organizational reporting structure (§157.126(h)(22)).
Attachment 15c

Is the TPM or their designee a member of the nurse staffing committee?
☐ Yes ☐ No

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Emergency Department Medical Director

30. Provide the name and credentials of the Emergency Department (ED

a. Is the emergency department medical director board-certified or
☐ Yes ☐ No
b. If they are not board-certified or board-eligible, do they meet th physician requirement exception approval?
☐ Yes ☐ No

c. If yes, attach the *Physician Requirement Exception Request* docu
Attachment 30c

d. Describe the role and responsibilities of the ED Medical Director.

e. Attach the tracking document for the Emergency Department Ph
Attachment 30e

31. Do all ED nurses responding to arriving trauma activation patients h in TNCC or ATCN, ENPC or PALS, and ACLS within 18 months of hire
☐ Yes ☐ No

30

Advanced Practice Providers

47. Complete the table below for all Advanced Practice Providers (APP) who trauma activation team and involved in the initial evaluation and resusc patients.
Have the ATLS certifications available if requested.

APP Name	ATLS ID	Expir

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Trauma Registry Staffing Requirements

48. What is the annual trauma registry volume for the 12-month reporting period?

49. Does the facility meet the ACS staffing requirements for trauma registrars?
☐ Yes ☐ No

50. If the facility utilizes a pool of trauma registrars or a contract agency, the facility must have a defined registrar assigned to the facility(§157.126(h)(28)(B)).

Does the facility utilize a trauma registrar pool?
☐ Yes ☐ No

If yes, provide the name of the assigned registrar and their contact information.

Name | Credentials

Contact Phone | Contact Email

Certifications

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51. Complete the table below for the registry professionals completing the registry abstraction, data entry, and, coding activities.

Name, Credentials and Hire Date	Completed AAAM Course	Completed ICD-10 Course	Completed Trauma Registry Course	CAISS Certification

52. Attach the CAISS certificate(s) of the trauma registrar(s).
Attachment 52

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Performance Improvement Staffing Requirements

56. Define whether the facility meets the ACS Standard (4.35) regarding Performance Improvement (PI) personnel staffing requirements.

57. Attach the job descriptions for the trauma PIPS personnel.
Attachment 57

58. Complete the table below regarding the trauma PIPS personnel.

Name, Credentials, and Hire Date	Date Completed TOPIC Course	Certified in ATCN or TNCC, Instructor	Certified in ENPC or PALS, Instructor	TCRN Certified, TCAR or PCAR	Total CNEs in Reporting Period

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61. Attach the facility's disaster plan which includes the surge capacity and capabilities emergency department (ED), surgical intensive care unit (ICU), operative suite, an inpatient units.
Attachment 61

62. Provide the name and credentials of the trauma surgeon serving on the disaster co

63. Provide the percentage of the meetings the individual attended during the 12-mont reporting period.

%

64. Attach the documentation from the trauma program's last mass casualty training (s for surgical surge capacity in the OR, emergency department, and ICU), and includ attendance roster §157.126(h)(30).
Attachment 64

65. Attach the job action sheets utilized in the mass casualty training

35

date for each of the following management guidelines and attach a copy

Guidelines	Date of Last Revision	Attach Guideline
		Attachment #67a
		Attachment #67b
n		Attachment #67c
esponse		Attachment #67d
r		Attachment #67e
		Attachment #67f
anagement		Attachment #67g
on, if utilized		Attachment #67h if utilized
		Attachment #67i
		Attachment #67j
RA		Attachment #67k
mergency physician shared		Attachment #67l
gement		Attachment #67m
:		Attachment #67n
al protocol		Attachment #67o
na management based on ated and managed		Attachment #67p
		Attachment #67q
gement		Attachment #67r
ment, if Level III-N		Attachment #67s

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Pediatric Readiness (ACS 5.10) and (§157.126(h)(12))

73. Define the facility's pediatric assessment readiness score for the 12-month reporting period.

74. What were the pediatric assessment readiness scores for the previous two years?

List the opportunities identified during the pediatric readiness assessment and define action plan for the 12-month reporting period.

Date of assessment

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ied or Opportunity	Corrective Action Plan	Status: Open vs Closed with Resolution
		Select one
		Select one
		Select one
		Select one
		Select one
		Select one
		Select one
		Select one
		Select one
		Select one

ess used to maintain the required pediatric trauma equipment in the . Include the process for staff education and skills credentialing specific to oment.

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76. Describe how documentation is monitored for pediatric vital signs and Glasgow Coma Scale (GCS) assessments.

77. Attach the monitoring data for pediatric vital signs and GCS documentation assessments for the 12-month reporting period.
Attachment 77

78. Describe the facility's monitoring process for the pediatric imaging ALARA guidelines.

79. Attach the documentation of the pediatric simulation and the critique of the simulations completed during the 12-month reporting period.
Attachment 79

80. Does the facility meet the exemption criteria for the pediatric simulation requirement by managing 200 or more patients under 15 years of age that have an ISS of 9 or greater?
☐ Yes ☐ No

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Trauma Transfers

86. Describe the trauma program's process for monitoring the timeliness and coordination of trauma patient transfers.

87. Attach the data reflecting the monitoring of trauma transfers for the 12-month reporting period.
Attachment 87

88. Attach a report reflecting the reasons for trauma transfers over the 12-month reporting period.
Attachment 88

89. Describe the communication process for trauma transfers both into and out of the facility.

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Diversion

90. Attach the facility's trauma diversion protocol.
Attachment 90

many total hours was the facility on trauma diversion during the 12-month reportin
od?

ch the facility's trauma diversion tracking and review data.
achment 92

the trauma diversion hours and reasons reported to the Trauma Operations Committ
esolve the causes of diversion?
es ☐ No

version is not reported to the trauma operations committee, where is this informatio
orted?

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Trauma Quality Improvement Program (TQIP)

143. Does the trauma facility participate in TQIP?
☐ Yes ☐ No

144. If no, attach the two most recent risk-adjusted benchmark reports from the alternative risk-adjustment benchmarking program. At least one report must have been received during the facility's 12-month reporting period.
Attachment 144

145. Briefly describe the opportunities for improvement and the actions taken to improve patient care that were identified during evaluation of the risk-adjusted benchmarking report. Be sure to include any relevant issues concerning data quality.

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;ing Orientation

process for trauma orientation, education and credentialing ICU nurses
e general in-patient units. Include a list of orientation materials they receive.

redentialing checklist for ICU nurses that is specific to trauma care.
163

e table below for nursing education and course activity during the 12-month
riod.

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Nursing Education and Course/Activity	% of ED Nurses that Completed Training	% of ICU Nurses that Completed Training	% of PACU Nurses that Completed Training	% of Floor Nurses that Provide Care to Trauma Patients that Completed Training
ENPC	%	%	%	%
PALS	%	%	%	%
ACLS	%	%	%	%
TCAR	%	%	%	%
PCAR	%	%	%	%
PTACC	%	%	%	%
TNATC	%	%	%	%

165. If the facility provides trauma training specific to pediatric trauma patients, define the training programs offered (applicable to non-pediatric trauma facilities).

44

166. Describe the trauma program's involvement in training prehospital personnel. Be sure to include if the program has EMTs or Paramedics rotate through the ED, OR, or ICU for training, or assist with programs through the RAC.

167. Describe the facility's communication capabilities with EMS professionals, specifically detailing its redundancy and backup systems.

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Level III Trauma Facility Self-Assessment, July 2025

ACS STANDARD / TEXAS REQUIREMENT	TYPE	LIII (LIII-NE)*	MET	NOT MET	COMPL COMI
policies and oversight of the program. In trauma centers undergoing a consultation or initial verification review, the TPM must have at least 12 hours of trauma-related CE during the reporting period.					
Trauma Program Manager Responsibilities and Reporting Structure In all trauma centers, the TPM must have a reporting structure that includes the TMD and they are to assume at minimum, the following leadership responsibilities in conjunction with the TMD and/or hospital administrator.	Type II	x			-Relevant organi -Role profile/des highlights the res the TPM

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Survey Planning

1. Review the data and information objectively as compared to the ACS standards and designation requirements
2. If not clear about the information meeting the requirement, ask clarifying questions
3. Do not render opinions
4. Look for documented evidence each requirement is met

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Medical Record Review

Each surveyor is required to review ten medical records.

The number of medical records prepared is based on the following:

- Adult Program Level I or II: 50 medical records • Pediatric Program Level I or II: 50 medical records
- Combined Adult and Pediatric Programs:
  - Adult Level I or II and Pediatric Level II: 75 medical records (50 adult medical records and 25 pediatric medical records)
  - Adult Level I and Pediatric Level I: 90 medical records (45 adult medical records and 45 pediatric medical records)
- Level III Program:
  - 25 medical records for two surveyors ◇ 35 medical records for three surveyors
- Level IV Program:
  - 15 medical records for one surveyor ◇ 25 medical records for two surveyors
- Focused Surveys:
  - 15 medical records for one surveyor
  - 25 medical records for two surveyors

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	Age/Gender	Mechanism of Injury
MRN/Trauma Registry #		
Injury Category		
ISS		
EMS Scene Time / Summary Prehospital Whole Blood or Blood Component Administered		
Trauma Team Activation	Yes ☐ No ☐ Level: _____ Timely Activation ☐ Delayed Activation ☐	

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Conference Call 20 Days Prior to Survey

Lead	Lead Surveyor and Facility TMD, TPM, and Administrator
Clarify	Clarify agenda and discussion points prior to the call
Clarify	Clarify questions regarding DAQ, self-assessment, other documents
Select	Select the medical records
Focus on	Focus on completing the review of the documents
Set	Set agenda for the “Opening Conference”

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Prior to Survey

- **Begin to look at medical records**
- Specific documents in the medical record files
- Prepare for the Opening Conference
- **Walk-through review - Required for all initial and upgrade designation surveys or change in facility**
- **Group Interviews – Redesignation**
- **Survey schedule**
  - **Initial**
  - **Redesignation – two day**
  - **One-day**

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Survey Guidelines Schedule – Initial Designation

Day 1	
0715	Survey Team Arrives On-Site
0730	Survey Opening Conference/Morning Conference
0830	Facility Tour/Group Interviews
0930	Medical Record Review
1200	Lunch
1230	Closed Survey Team Meeting
1245	Medical Record Review
1630	Closed Survey Team Discussion
1700	Trauma Program Update

This survey is done in-person following the schedule outlined

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Survey Guidelines Schedule

Day 2	
0715	Medical Record Review
0930	Closed Survey Team Discussion
1030	Trauma Program Update
1100	Exit Conference
1145	Exit Building

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Survey Schedule 2; Day 1 (Redesignation)

Time	Activity
10 am - Survey Begins	Medical Record Review (Folders Prepared for Medical Record Review)
4:30 pm - Closed Survey Meeting	Surveyors List Findings: Requirements Not Met; OFI; Observed Best Practices; Regional Participation; Strengths
5:30 pm - Trauma Program Update (TMD, TPM, Administrator)	Surveyors Share Findings

If the requested start time is altered the facility must approve the start time and it is then approved by the department. The department will not approve a start time past 11 am. Survey can be in-person or virtually – it is the hospital's choice.

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Survey Schedule 2; Day 2

Time	Activity	
7:30 Surveyor Arrival	Morning / Opening Conference	**Start time may be altered if facility agrees to 8 am.**
8:30 – 9:30	Walk-Through / Group Interviews	
9:30 - 1100	Documentation / Medical Record Review	
1100 – 1130	Surveyor Exit Conference Planning	
1130 – 1145	Trauma Program Update	
1145 – 1215	Exit Conference	

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Survey Schedule 3; One Day Survey

Time	Activity
7:30 Surveyor Arrival	Morning / Opening Conference
8:30 – 9:30	Walk-Through / Group Interviews
9:30 - 1145	Documentation / Medical Record Review
1215 – 1530	Medical Record Review
1530 – 1600	Closed Conference
1600 – 1630	Exit Conference

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Opening Conference

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Key issues to cover during this opening conference

Opening conference agenda is defined by surveyors, TMD, TPM, Administrator during the 20 day-out call.

- Survey schedule and timelines.
- Introduction of the surveyors and facility staff.
- Key areas of improvement since the last survey, targeting the requirements not met at the last survey and defined weaknesses.
- Overview of the facility's role in the regional system.
- Structure of the trauma PIPS plan.
- Current trauma PIPS dashboard, benchmarking reports and examples of performance improvement initiatives that demonstrate event resolution during the designation cycle as agreed upon by the lead surveyor and TMD.
- Pediatric readiness compliance.
- Disaster preparedness activities specific to mass casualty events requiring a surgical response and surge for the trauma resuscitation area, operating room (OR), ICU, surgical subspecialties, and inpatient areas.
- Overview of the facility, demonstrating key areas involved in the trauma program and any improvements linked to improved trauma outcomes.

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APPENDIX H: FACILITY WALK-THROUGH REVIEW GUIDELINES

- Survey Walk-Through Assessment and Overview
- Resuscitation Area/Emergency Department (ED)
- Telemedicine
- Radiology
- Blood Bank
- Respiratory Therapy
- Operating Suite
- Post Anesthesia Care Unit (PACU)
- Intensive Care Unit (ICU)/Critical Care Unit (CCU)
- Surgical General Unit

APPENDIX I: EXAMPLES OF GROUP INTERVIEW

- Trauma Group Interview

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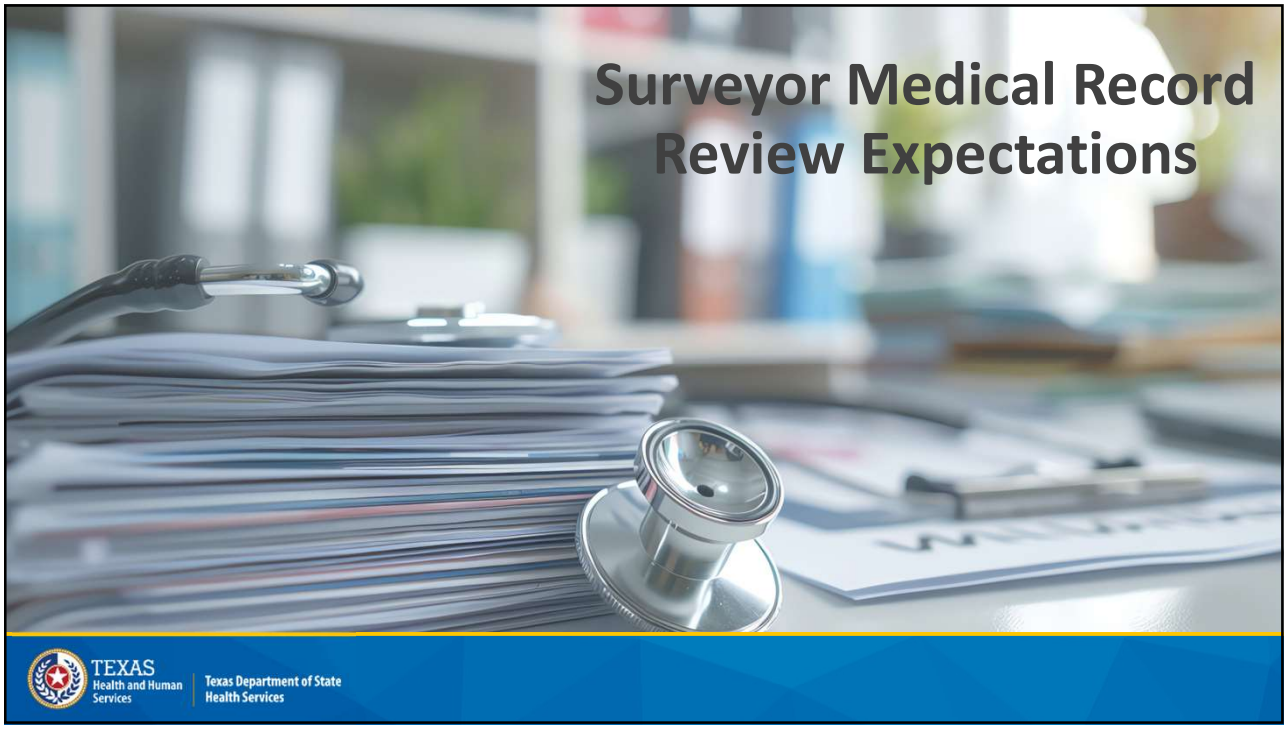

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Remember to Maintain HIPAA and Confidentiality

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Medical Record Review

Example: Medical Record Review Summary

• Prehospital response, assessment, and intervention to include if whole blood was administered • Hand-off • Wristband utilization • Helipad	
• TTA criteria and response times are met • Presenting vital signs • Level of activation • Response • Resuscitation guidelines followed are assessed	
• Timely availability of plain images, CT scan, IR, and Angio • Timeliness of radiologist reads • If radiology is requested, response time and availability of reads • Critical finding communication • Laboratory is available and response is appropriate • Timeliness of reporting lab results • Critical finding communication.	

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Medical Record Review

• MTP activation and blood product ratio • Whole blood utilization	
• Process if MTP is not available. • Prehospital whole blood process if applicable.	
• Age specific guidelines followed	
• Injuries identified • Plan of care	
• Admission to OR • Procedure review • Timeliness	

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Medical Record Review

• ICU admission • Admission criteria • Admission assessment • Trauma management guidelines followed	
• Inpatient admission • Trauma management guidelines followed • Continuum of care	
• Specialty services • Consulting services • Response times and documentation	
• SBIRT • Screening • Interventions • Referral	
• Abuse screening • Referral	

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Medical Record Review

• Mental health screening • Referrals	
• Psychosocial support available	
• Rehabilitation needs assessment	
• Discharge planning	
• Discharge status	
• Overview of trauma PIPS case review • Timeliness	
• Trauma registry abstraction • ISS coding • Calculations	
• Evidence trauma program has oversight authority	

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Telemedicine – County with Less than 30,000 Population

- Level IV facilities in a county with less than 30,000 population
- Telemedicine resources with an APP
- Telemedicine physician and APP assess patient collaboratively through video
- Telemedicine physician immediately available
- APP must be at bedside within 30 minutes (APP must maintain current ATLS)
- Follow document trauma resuscitation guidelines
- Documentation guidelines followed
- Documented telemedicine physician credentialing
- All assessments, physician orders, interventions and patient response is documented in the medical record

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Telemedicine in County Greater Than 30,000 Population

- Documented telemedicine credentialing process
- Trauma management guidelines and protocols for utilization of telemedicine
- Guidelines include expectations for physician response
- Evidence guidelines and response are monitored through PIPS
- Can not replace these requirements:
  - on-call physician to respond to the trauma activation in person
  - conduct inpatient rounds
  - Respond to emergency requests from the inpatient units when requested

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Telemedicine

- Telemedicine assessments, physician orders, and interventions initiated are documented in the medical record
- Telemedicine services or the telemedicine physician requested to assist with PIPS – evidence of involvement

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TMD

- TMD roles, responsibilities, and oversight are demonstrated through the medical record reviews and PIPS
- TAC 157.126 (h)(16) TMD must define the role and expectations of the hospitalist or intensivist in providing care to the admitted injured patient meeting trauma activation guidelines and meeting NTDB registry inclusion criteria

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Trauma Performance Improvement Patient Safety

- Identified patient care and facility system variances in care
- Primary level of PI review is completed no later than 14 days after the patient's discharge.
- Identified events and variances have
  - level of harm identified
  - levels of review
- TMD's secondary level of review including date
- Corrective actions are developed
  - implemented
  - monitored for outcomes with data
  - sustained with goals met
- Event resolution is documented

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Referred to Committee for Review

If the case is referred to the multidisciplinary operations committee or multidisciplinary trauma peer review committee, documentation must reflect

- attendance of individuals present
- the review and discussion of the case
- identified opportunities for improvement
- opportunities for improvement
- cycle of corrective action plans

Referred to other departments or committee – need to see the follow-up and action plans

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PIPS Process

If the case is a mortality

- documented evidence of a mortality review through the trauma PI process

Autopsies for mortalities are available

- injuries are listed and congruent with the trauma registry data.

Events/Morbidity/Mortality is categorized utilizing the terminology outlined in §157.126.

Evidence that events identified as "regional opportunities for improvement"

- referred to the identified provider
- regional performance improvement process for tracking.

Documentation of trauma PIPS review is objective, through, and consistent

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Missing Documents or Additional Needs

If you are missing documents for the medical record review or need additional information, please make the navigator aware of this ASAP and be specific about the request

- Hold the medical record until you receive the requested information
- Navigator will alert TMD and TPM of need
- Assigned individuals will provide the data
- TMD or TPM may discuss information to ensure medical record can be completed.

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Certifications and Credentials

- Surveyors may ask for the nurse's or physician's credentials as they review a medical record.
- If requested, please review and provide written comments in the medical record review summary.

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Transfers

- ACS 5.1, ACS 5.13, ACS 5.14
- 157.126 (d)(2)
- 157.126 (h)(8)(D)
- 157.127 (h)(10)
- 157.126 (c)
- ACS 2014 (CD 2-13, 4-13, 14-D, 4-3)
- 157.126 (h)(32)(F)
- 157.126 (h)(31)(G)
- Transfer Review Process – All levels of trauma facilities
- Transfer in acceptance time
- Transfer feedback

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Trauma Registry

- Trauma registry data abstraction for the medical record being reviewed is accurate regarding
  - procedures performed
  - injuries defined
  - phases of care
- Trauma ISS calculation is accurate
- Validate abstraction is complete and coding is accurate
- Validate ISS is correctly calculated

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Medical Record Summaries

- Complete ten medical record summaries
- Validate the ACS standards and TAC requirements are met or not met with evidence that they were reviewed
- PIPS review
- Trauma registry review
- Trauma management guidelines review
- Document findings
- Telemedicine integration
- Review of hospitalist or intensivist role
- Two records – review of nurse's and physician's certifications, credentialing

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Document Review

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Requested Documents

- Documents in the Shared File
- Additional requested documents
- Validate requirements are met through documented evidence

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Key Leader Interviews

- Surveyors/department request interviews.
- Interviews can be closed or open.
- Focus on ACS standards and state designation requirements.
- Do not ask, “What do you want us to put in report, or what do you need us comment on.”
- Objective discussion regarding the standards and requirements.

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Surveyor/Department Closed Meetings

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Closed Surveyor Meetings

- Surveyors and department
- Focus on objective findings
- Evidence requirements are met or not met
- List items
  - Potential requirements not met
  - Opportunities for improvement
  - Regional participation
  - Observed best-practices
  - Strengths

When complete, share the findings with the TMD, TPM, and the Administrator.

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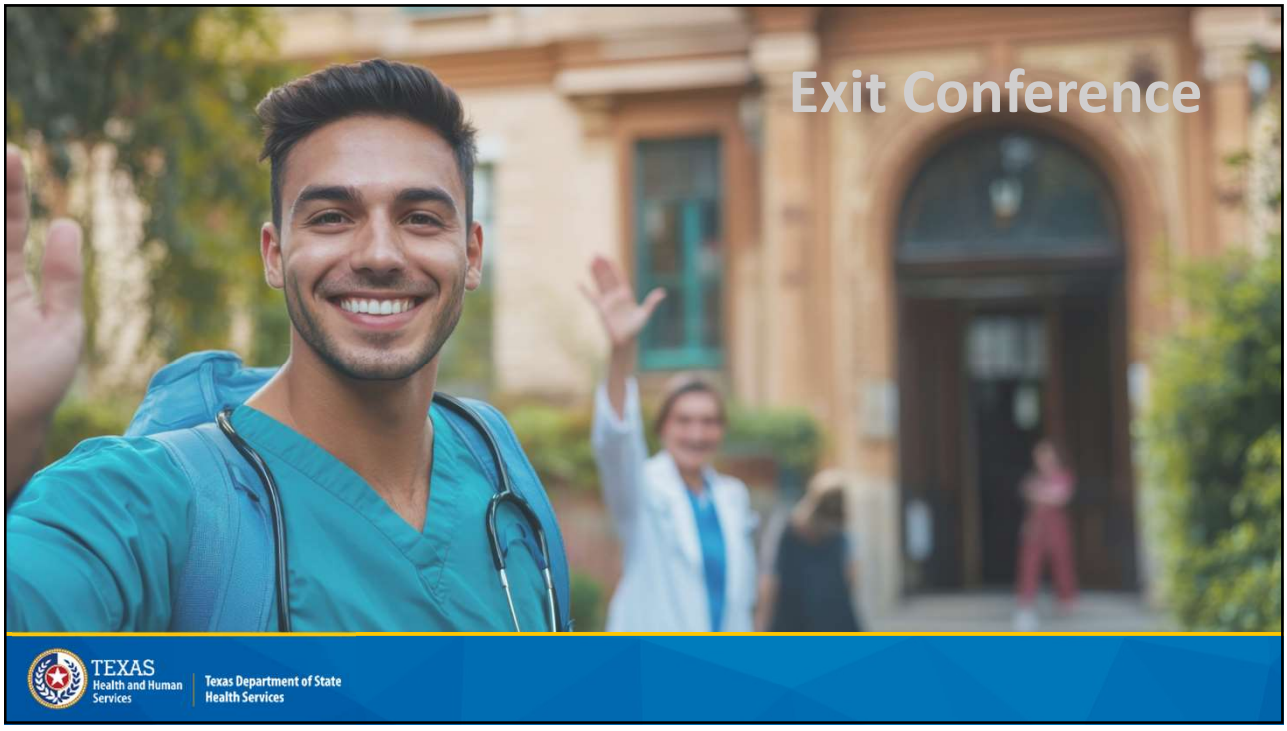

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The lead surveyor will read the following statement:

The survey team has completed your trauma designation survey. Based on the survey findings, we will begin with the potential requirements not met, opportunities for improvement, regional participation, observed best practices, and strengths of the program. We will provide you the survey team's recommendations to meet specific designation requirements the facility is potentially not meeting consistently.

It is important to note that the survey team's role is to validate the designation requirements are met. The survey team nor the survey organization have the authority to designate a facility. Designation is determined by the department. The survey team will complete the designation survey summary report and forward the report and all medical record reviews to the trauma medical director and program manager within 30 days of the survey. It is important to note that the facility is responsible for submitting the designation survey summary report, medical record reviews, and all necessary documents to the department to complete the designation process.

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Exit Conference

The lead surveyor and survey team will review the following:

- Requirements not met
- Opportunities for improvement
- Regional participation
- Observed best practices
- Program strengths
- Recommendations

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Summary Reports

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Survey Summary Report

- Survey TAC 157.126 requirements summary checklist
- Medical record review summaries
- Sent to lead surveyor – physician if two surveyors
- Ensure all identified issues are brought forward in summary report
- Consistency of report

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Survey Executive Summary Report

Survey Findings	
Requirements Not Met (Provide specific ACS Standard/TAC Rule)	List Designation Requirements Not Met and Provide the Medical Record(s) Reviewed
Opportunities for Improvement (Provide Specific ACS Standard/TAC Rule)	List Designation Requirements with Opportunities for Improvement and Provide Medical Records Reviewed as Appropriate

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Survey Executive Summary Report

Regional Participation	Define Regional Participation for the Designation Cycle
Observed Best Practices	List Observed Best Practices Identified During the Survey
Program Strengths	List Program Strengths Identified During the Survey
Recommendation (Provide specific recommendation for each ACS Standard/ TAC Rule not met)	Provide a Recommendation for Each Requirement Not Met

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ACS and TAC Requirement Checklist

- Complete
- Through
- Demonstrates or references documented evidence
- References medical records as appropriate
- Refer to specific documents that have opportunities for improvement

Ensure that the TMD, TPM, and the Administrator are aware of findings.

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Survey Summary Report

COORDINATION BETWEEN SURVEYORS

REPORT COMPLETED AND TO FACILITY WITHIN 30 DAYS

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Department Review

Report is sent to department with other required documents

Department reviews the summary reports to ensure report aligns with expectations outlined in the survey guidelines

If variations are identified, information is sent back to the survey organization

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Summary

- The survey process
  - validates all requirements are met or not met
  - follows the trauma designation survey guidelines
  - creates transparency with the facility TMD, TPM, and Administrator
- Documents
  - DAQ, self-assessment, and all documents in shared file are reviewed.
- Call with facility
  - 20 days-prior to survey
  - clarify agenda with TMD, TPM, Administrator
  - select medical records for review
  - define agenda for Opening Conference
- Medical review
  - time management
  - HIPAA compliance
- Closed meeting
  - be prepared to share findings
- Exit Conference
  - read opening statement
  - review the findings
- Survey summary report
  - completed and to facility within 30 days

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Thank you for your time, commitment, and expertise.

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