CONSUMER PROTECTION DIVISION
EMS TRAUMA SYSTEMS SECTION

TRAUMA DESIGNATION SURVEY GUIDELINES

TEXAS Health and Human Services
Texas Department of State Health Services

Table of Contents

DESIGNATION SURVEY GUIDELINES GOALS

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 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.

Submit questions specific to the trauma designation survey guidelines to:
DSHS.EMS-TRAUMA@dshs.texas.gov.

Survey Expectations

Each trauma designated facility in Texas must have an evaluation process to validate that the facility has documented evidence the Texas Administrative Code (TAC) Section 157.126 requirements and the American College of Surgeons (ACS) verification standards are met. Level IV trauma facilities managing 100 or less patients meeting the National Trauma Data Bank (NTDB) registry inclusion criteria are not required to meet ACS standards. The validation process is accomplished by a facility survey, onsite or virtually.

Facilities are required to complete a designation survey application and contact a department-approved survey organization or the department to schedule their designation survey.

- **Level I and Level II trauma facilities** must use the ACS as their survey organization.
- **Level III trauma facilities** may choose the ACS or a department-approved survey organization.
- **Level IV trauma facilities that manage 101 or more patients** meeting the NTDB registry inclusion criteria will use a department-approved survey organization.
- **Level IV trauma facilities that manage 100 or less patients** meeting the NTDB registry inclusion criteria may choose a department-approved survey organization or the department to complete their trauma designation survey.

The surveyors selected by the department-approved survey organization must meet the department surveyor requirements, and the training and educational requirements outlined by the department. The surveyors must have evidence of credentialing as a surveyor by the survey organization. Surveyors are required to complete a survey training program and then observe a survey. The observing surveyor in training will complete a minimum of three medical record reviews during the observation survey and have the medical record summaries reviewed by their assigned mentor. If approved by their mentor the surveyor can then complete a survey with a mentor observing their performance.

The mentor and the survey organization must have a documented critique of the surveyor in training that demonstrates the surveyor reviewed all documents in the survey-shared-file approved by the department prior to the day of the survey. The critique must document that the surveyor in training demonstrated successful communication skills during the survey planning call, morning conference, medical record reviews, closed sessions, and exit conference.

The surveyor in training must meet the requirements for documenting evidence the requirements are met and successfully complete 10 medical record reviews. The medical record reviews must have documented evidence the designation requirements are met, and the identification and management of trauma performance improvement activities are effective. The survey organization must have documented evidence of surveyor training available if requested by the department.

Designation Survey Overview

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.

Survey team composition is defined by the level of designation in §157.126.

- **Level I and II trauma facilities** require a survey team comprised of two surgeons, an emergency medicine physician, and a registered nurse with trauma expertise.
- **Level III trauma facilities** require a survey team comprised of a surgeon and a registered nurse with trauma expertise.
- **Level IV trauma facilities managing 101 or more patients** meeting NTDB registry inclusion criteria annually that have evidence of trauma patients having operative interventions, admission to the Intensive Care Unit (ICU), or having an ISS of 15 or greater require a surgeon and a registered nurse with trauma expertise.
- **Level IV trauma facilities managing 101 or more patients** meeting NTDB registry inclusion criteria annually that do not have evidence of trauma patients having operative interventions, but have trauma patient admissions to the ICU and have an ISS of 15 or greater require a survey team comprised of a surgeon, emergency medicine physician, or family practice physician, who is serving as a trauma medical director (TMD) or trauma liaison, and a registered nurse with trauma expertise.
- **Level IV trauma facilities managing 101 or more patients** meeting NTDB registry inclusion criteria annually that do not have evidence of trauma patients with operative interventions or ICU admissions require a survey by a surgeon, emergency medicine physician, or family practice physician, who is serving as a TMD or trauma liaison, or a registered nurse with trauma expertise.
- **Level IV trauma facilities managing 100 or less patients** meeting NTDB registry inclusion criteria annually require a survey by a surgeon, emergency medicine physician, or family practice physician, who is currently serving as a TMD or trauma liaison, or a registered nurse with trauma expertise.

The department-approved survey organization, the facility, and surveyors are responsible for defining any actual or potential conflicts of interest as defined in the designation rules. Survey reports completed by a surveyor(s) that has a known potential or actual conflict of interest may not be accepted by the department. Questions regarding a surveyor conflict of interest, may be clarified in §157.126 rule language or by contacting designation staff for clarification.

In addition to the survey team, department designation staff may attend the survey. The department designation staff member has the authority for the oversight of the designation survey and serves as a resource to the facility and survey team.

Exceptions To Designation Requirements

Facilities may request an exception to a specific designation requirement. The facility must submit the Trauma Facility Designation Rule Exception Request Form electronically to DSHS.EMS-TRAUMA@dshs.texas.gov. The request for a designation requirement exception must be received, reviewed, and approved prior to the facility scheduling a designation survey.

Facilities must have evidence that all other requirements are met and submit a documented plan of correction (POC) with a timeline to address the designation requirement. The facility will work with the department to track the progress of the corrective action(s). Facilities may refer to the specific designation rule language for further information.

- The Trauma Designation Review Committee reviews the trauma designation exception requests.
- The designation exception request must be reviewed and approved prior to scheduling a designation survey.
- The Trauma Designation Review Committee meets quarterly during the Governor's EMS and Trauma Advisory Council (GETAC) meetings.

The Trauma Designation Requirement Exception Form requires a facility to identify the trauma volume and activity during the designation cycle. For questions on completing the form, please contact the designation staff or the EMS Trauma Systems Section Director.

Link to Trauma Facility Designation Rule Exception Request
Link to Physician Requirement Exception Request

SURVEY PLANNING GUIDELINES

The purpose of the survey is to validate the facility has documented evidence the state designation requirements and ACS verification standards at the level of designation requested by the facility are met. This is applicable to facilities seeking initial designation or renewal of designation. The agreement between the department-approved survey organization and the facility must ensure any actual and potential conflicts-of-interest are not present, and measures to ensure the environment for the survey process fosters cooperation between the surveyors and the facility's program staff.

Evidence of designation requirements met are determined by:

1. Consistent clinical care that meets or exceeds the established trauma management guidelines and current evidence-based practice, evaluated by the care documentation in the medical records reviews.
2. Concurrent, effective trauma performance improvement and patient safety (PIPS) processes that are integrated into the facility's and region's processes, and consistently demonstrate variances in care are identified, level of harm is identified, and the variance is moved through the performance improvement levels of review with defined corrective actions that demonstrate event resolution.
3. Documented policies, procedures, protocols, and management guidelines specific to the trauma population served and specific to the facility are documented and available through the continuum of care.
4. Evidence of data management and submission of required data to the State Trauma Registry every quarter and within the specified timelines.
5. Validation that required resources are available.
6. Validation that staffing required for the trauma performance improvement processes and trauma registry are in place.
7. Validation that trauma activation guidelines are established and followed, and the team members and physician responses meet the requirements.
8. Interviews with facility program staff, medical staff, administrative leaders, and key clinical individuals participating in the trauma program demonstrate knowledge of the program's operational plan, trauma PIPS plan, trauma management guidelines, their role in the system, and overall commitment to trauma care within the facility.
9. Documented evidence of outreach education, training programs, and prevention programs.
10. Evidence of documented Regional Advisory Council (RAC) participation for the designation cycle.
11. Evidence of regional and facility participation by the TMD and trauma program manager (TPM) in disaster management and response training.
12. Documented evidence that all trauma designation requirements are met.

The survey may be halted if the surveyor's capacity to complete the survey responsibilities is impeded. Examples of situations that impede the survey are listed.

1. A facility staff member whose behavior impedes the ability of the surveyor to discuss cases, review medical records, complete interviews, or review program documentation.
2. Lack of access to medical records, medical record trauma performance improvement documentation, or data due to technical performance, access issues, or information technology (IT) failures.
3. Falsification of any documents specific to the site survey process.
4. Surveyors or facility staff members who demonstrate non-professional behavior.
5. An unexpected event occurs that impacts the facility, the facility's staff members, or a surveyor.

The department designation staff have the authority to stop a survey or call for clarification when present. If department staff are not present, the facility must call the department to review the event.

The department will investigate the situation and determine the next step, which may include rescheduling the survey or other activities defined by the nature of the event.

Designation Survey Process

Initial Trauma Designation

Non-designated facilities seeking trauma designation at any level have the option of completing an in-active-pursuit (IAP) of designation application. Completing this application allows the facility to be included in the trauma uncompensated care (UCC) funding provided by the department.

Non-designated facilities seeking initial trauma designation must schedule a conference call with the department and include the facility's chief executive officer (CEO), chief operation officer (COO), chief nursing officer (CNO), trauma administrator or executive leader, TMD, and TPM before scheduling their designation survey. The following information must be provided to the department before the scheduled conference call:

- Job descriptions for the TMD, TPM, and trauma registrar;
- Trauma operational plan;
- Trauma PIPS plan;
- Trauma activation and trauma management guidelines; and
- Trauma registry procedures.

The conference call will include the EMS/Trauma Systems Director, Designation Manager, and the assigned designation coordinator. The meeting is scheduled for 60 minutes. The meeting agenda includes the following:

- Introductions of facility staff
- Introductions of department staff
- Facility's review of
  - ◇ Commitment
  - ◇ Support for required roles and responsibilities
  - ◇ Overview of the facility's trauma operations
  - ◇ Overview of the trauma PIPS plan

- ◇ Overview of the trauma activations and trauma management guidelines
- ◇ Overview of the trauma registry and submitting data to the state trauma registry

- Department review of
  - ◇ Documents submitted
  - ◇ Designation Assessment Questionnaire (DAQ)
  - ◇ Designation process
  - ◇ Identified next steps

Trauma Facility Redesignation

Facilities seeking redesignation will complete the trauma designation application and submit the documents to the department between 18 to 12 months prior to their anticipated survey date. Once the facility designation application is received, the department will send the DAQ to the facility.

Note: Level I and II trauma facilities will utilize the ACS Pre-Review Questionnaire (PRQ) and will follow the ACS survey process to complete their survey. Level I and Level II facilities are required to complete the State DAQ addendum to ensure the state designation requirements are met.

Facilities will have the opportunity to attend the DAQ learning sessions once the trauma designation application is received by the department.

Facilities will complete the DAQ prior to facility's designation survey.

Facilities seeking redesignation must submit the following documents to the department **no later than 90 days** before their current trauma designation expiration date:

- Completed trauma designation application for the requested level of trauma designation;
- Completed DAQ;
- Documented trauma designation survey summary report that includes findings of requirements and standards met and not met, and the medical record review summaries;
- Evidence of documented submissions every quarter and data validation to the State Trauma Registry and NTDB (if applicable) for the past 12 months;
- Evidence of the trauma program's participation at RAC meetings throughout the designation cycle; and
- Full payment of the non-refundable, non-transferrable designation fee and department remit form submitted to the DSHS Cash Receipts Branch per the designation application. If the remit form or account deposit information is not sent with the payment, the payment will be returned.

Contacting the Survey Organization

The facility seeking designation or renewal of designation will define their survey organization of choice on the designation application. The facility will complete the trauma designation application and submit it to the state to gain access to the DAQ. The survey date needs to ensure that receipt, review, and development of a POC for requirement(s) not met can be accomplished prior to the submission of the designation survey documents to the department. The facility must submit the entire designation application packet to the department within 90 days of the survey date and no less than 90 days before the expiration of the current designation. See Appendix A for a list of current department-approved survey organizations and their contact information.

The facility must have the required documents available and organized for the designation survey. These include:

- Documentation of 12 months of trauma PIPS reviews;
- 12 months of minutes and attendance of the trauma operations meetings;
- 12 months of trauma multidisciplinary peer review committee meetings and attendance;
- Documented trauma management guidelines or evidence-based practice guidelines;
- All trauma related policies and procedures;
- Evidence of 12 months of trauma registry submissions every quarter to the State Trauma Registry with evidence of data validation;
- Documentation of all injury prevention, outreach education, and public education;
- Research and peer journal publications (specific to Level I trauma facilities);and
- Documented evidence all designation requirements are met (demonstrated by the completed designation self-assessment).

Survey Preparation

The facility will focus on survey planning and preparation. This includes the completion of the DAQ. The DAQ is included with the documents submitted to the shared file a minimum of 45 days before the scheduled survey.

The facility will complete the Trauma Designation Application and submit to the department not greater than 18 months prior to the anticipated survey date. Once this is completed, the department will send the DAQ to the facility. The facility will have the opportunity to attend the monthly DAQ training session, coordinated by the department that focuses on completing the DAQ and preparing for their designation survey.

The facility will include the completed DAQ and required documents in a shared file created for the facility survey. This shared file allows the department and surveyors access to the documents necessary to complete the designation survey. The facility's CNO, Chief of Information Technology (IT), and trauma program leaders approve the shared file platform to ensure the processes are compliant with the rules and laws related to confidentiality and Health Insurance Portability and Accountability Act (HIPAA).

Note: Level I and Level II trauma facilities will utilize the ACS PRQ and not the DAQ. Level I and Level II facilities are required to complete the State DAQ addendum to ensure the state designation requirements are met.

The survey process is designed to evaluate a specific facility, and the care provided in the identified facility. Representatives from the facility's system may attend the survey as a silent partner. The facility's trauma program leaders and staff are responsible for leading the survey and responding to all questions from the surveyors.

Preparing Survey Documentation

The facility's trauma program leaders and staff are responsible for preparing and organizing the required documents. Documents must be loaded into the shared file 45 days prior to the survey and be immediately available to facilitate the survey process when on site. It is important to note, the oldest medical records for review cannot be greater than 12 months prior to the survey, unless approved by the department. The facility must complete and submit the DAQ and all required attachments to the shared file and prepare the following documents for the survey:

1. Trauma program organizational chart including the reporting structure and number of full-time and part-time equivalents (FTEs).
2. Facility's organizational chart reflecting the reporting structure of the trauma program.
3. Operational budget that supports the trauma program.
4. Trauma program's annual PIPS plan summaries (dashboards) for the designation cycle. Include the list of the trauma screening events utilized by the facility. See Appendix B for a list of common screening events.
5. Current trauma program operational plan.
6. Job Descriptions (as applicable)
    a. Administrator responsible for the trauma program
    b. Trauma Medical Director
    c. Trauma Program Manager/Director
    d. Trauma PIPS Personnel (assisting the designation program)
    e. Lead Trauma Registrar/Data Manager
    f. All Advanced Practice Providers (APPs) participating in the trauma program, identifying those that participate in trauma activation resuscitations or evaluations.
    g. Outreach Education Coordinator (if separate from one of the other positions)
    h. Injury Prevention Coordinator
    i. Other personnel dedicated to the trauma program
    j. Other support personnel (e.g., Social Worker, Case Manager, Psychologist, Geriatrician, Child Life Specialist)
    k. Physician Trauma Liaisons
7. Registry or data management plan. See Appendix C for registry or data management inclusion criteria.
    a. Trauma program data management plan defining inclusion criterion, data dictionary utilized, abstraction and data entry process, and data validation process.
    b. Level III facilities will include their last Trauma Quality Improvement Program (TQIP) benchmarking report.
    c. Level IV facilities will include their benchmarking targets.
8. Documented evidence of submissions to the State Trauma Registry every quarter. Documents reflecting the data validation and corrective actions as appropriate for the past 12 months or designation survey timeline.
9. Patient care records beyond the timeframes submitted in the application but within the designation cycle may be requested for review. Processes to expedite these requested records must be in place for the survey process.
10. Documentation of all outreach education, public education, injury prevention, and research activities for the selected time must be available for review (as applicable). See Appendix D for Research and Publication Tracking.
11. Documentation of processes and evidence of how the facility monitors designation requirements to ensure they are met, must be available for the surveyors, if not included in the documented PIPS plan and trauma operations committee.

12. A list of selected medical records for review as defined by the trauma designation level requested and their completed face sheets. The requested medical records are trauma activation patients that meet the selected criteria. Medical record reviews for the survey should be reverse chronological order, starting with the most recent months and moving backward. Medical record preparation includes the face sheet and copies of the admission history and physical (H&P) and the discharge summary documents.

13. Map of referral area, identifying rural areas or transport challenges.

Preparing for the Operational Processes of the Survey

1. Prepare the Survey Documentation

    a. Convert documents into a portable document file (PDF).

    b. Bookmark files through Adobe Acrobat Pro® or other premium products to organize the documents.

    c. Label and categorize the documents requested in the PRQ or DAQ, and other documents as appropriate to ensure all requested documents are available and easily accessed.

    d. Share documents via an electronic HIPAA-compliant transfer or sharing system such as secured email, DropBox, SharePoint, ShareFile, or any system approved by the facility's Chief of IT, Chief of Quality, and CNO.

    e. Documents must be available to share electronically with the survey team and department designation staff a minimum of 45 days prior to the survey. Trauma program staff will notify the surveyors and department when the documents are available and provide instructions for accessing the files.

    f. Facility must have completed business agreements and have all confidentiality forms signed by the survey team a minimum of 45 days prior to the survey.

2. The TMD and TPM will contact the lead surveyor and schedule a pre-survey conference call with the survey team a minimum of 20 days prior to the survey. The purpose of this call is to identify any outstanding logistics or document requests and define processes to move forward. The pre-survey conference call agenda will consist of these items at a minimum:

    a. Outstanding logistics for the survey

    b. Discussion of missing or outstanding documents or items

    c. Clarification or questions related to the documents in the shared file

    d. Changes that have occurred in the program since the last survey

    e. Updates to any previous requirements not met or identified opportunities for improvement from the previous trauma designation survey

    f. Medical record preparation and selection

    g. Administrative overview and support of the program

    h. Review of any requests for an physician requirement exception for a physician. When a physician who is required to be board certified or board eligible is not board certified or board eligible, the facility must complete an Physician Requirement Exception Request for that physician and request an exception to a designation requirement. The exception request has to be reviewed by the Designation Review Committee prior to scheduling a designation survey. Contact the department for questions.

3. The facility will develop a process to orient the surveyors to the electronic medical record (EMR) and the trauma PIPS process and associated documents. **Note**: This may be a pre-survey conference call agenda item for the facilities that choose a virtual survey.

4. The facility will ensure all necessary business agreements with the surveyors, which allow access to the EMR and PIPS documentation, are completed a minimum of 45 days before the survey date.

5. Each surveyor and department designation staff will need an identified EMR navigator who has the skills, proficiency, and access to all phases of care, transitions in care, progress notes, consult notes, diagnostic imaging, lab reports and all documents needed to complete a medical record review during the survey process. The individual must be knowledgeable of the trauma program's PIPS processes, registry, and data management process.

6. The facility will prepare a folder for each of the potential medical records for review that includes all associated PIPS documents, associated trauma management guidelines, the trauma registry data abstraction profile, and any benchmarking documents. **Note**: The surveyor may request to review a physician's, nurse's, consulting physician's, APP's, or other individual's training, credentialing, certifications, and educational records that are pertinent to the medical record being reviewed during the medical record review process. These documents must be organized and readily accessible.

7. The facility prepares the medical records for review following the directions of the lead surveyor and these guidelines. The medical record face sheet, admission H&P notes, and discharge summary provided in the shared file allow the survey team to review the complexity of the care provided. The survey team will complete the selection of the medical records for review at the meeting scheduled 20 days prior to the review. Please see Appendix E, Medical Record Guidelines and Face Sheet. **Note**: Each surveyor must complete 10 medical record reviews during the survey.

8. The facility will review its previous trauma verification/designation surveys and survey outcomes and be prepared to discuss improvements made to address any requirements or standards not met and any opportunities for improvement.

9. The department designation staff will have the trauma facility's state registry report of all submissions to the State Trauma Registry for the designation cycle, including the ISS breakdown, emergency department (ED) disposition, hospital discharge, and the incidence of missing data available. These reports will be shared with the survey team, as necessary.

10. Trauma facilities will include any approved designation requirement exception and any approved physician requirement exception in the shared file 45 days prior to the survey.

11. The facility will prepare a folder for the surveyors and department designation staff that includes the following information:

    a. Survey agenda
    b. Name and title of attendees at each session of the survey to include the pre-survey conference call, morning conference, and exit conference.
    c. Copies of all presentations used throughout the survey (maximum of 3 slides per page)
    d. Hospital newsletter, program annual report, or other pertinent program information.

    Note: No gifts may be accepted by the surveyors or department designation staff.

12. The trauma program leaders are responsible for ensuring the survey date is on the calendars of the facility CEO, CNO, Chief Financial Officer (CFO), COO, Chief Medical Officer (CMO), all physicians taking call for the trauma program, trauma liaisons, leaders of all departments, and nursing units that provide care to the trauma patient population. Educators, social services, rehabilitation, laboratory and blood bank, radiology, IT, engineering, and security need to be included in this notification and pertinent planning meetings.

13. The program leaders are responsible for ensuring that the Chief of IT and IT representatives are aware of the survey date and that the facility has all resources immediately available, including an IT representative available onsite to respond quickly to assist with any technology issues that develop during the survey.

14. The facility's CNO, Chief of IT, and program staff will define the platform used for a virtual survey with the surveyors. The platform needs to be tested during the pre-survey conference call with the surveyors.

15. The facility will address parking arrangements for the survey team, as necessary.

16. The facility will address any travel and hotel logistics necessary for the survey team if not addressed by the survey organization.

17. The facility is responsible for the meals during the survey process.

18. The facility is responsible for establishing measures to ensure HIPAA compliance during the survey process and that HIPAA measures are maintained throughout the survey process.

Medical Record Preparation

The medical record selection is outlined in Appendix E. The medical records selected should not include records greater than 12 months prior to the survey date, unless approved by the department. In a facility with limited volume, the medical records may include records for the entire three-year designation cycle to include deaths and complex cases, if approved by the department. For a focused or full survey of the program due to contingencies, the medical record review will not include records before the original survey date. Each surveyor is required to complete 10 medical record reviews and provide a medical record summary.

Note: The medical record summary provides documented evidence that the trauma requirements and standards are met as well as trauma activation and management guidelines are followed.

The room for the medical record review must be large enough to accommodate the survey team, department staff, and required trauma program staff. Each surveyor review space must have two computer monitors with a minimum of 22-inch screens, two keyboards, and a mouse for each individual. The review space must accommodate a surveyor and a navigator. The room must have reliable internet capability and capacity. The TMD, TPM, registry and data management staff, and identified PI personnel must remain in the room to answer questions. If other key individuals remain in the room, the space must accommodate these additional individuals. All individuals who remain in the room must be cognizant to keep voices and noise to a minimum unless they are answering surveyor questions. The only discussion in the room should pertain to the designation survey process. If other discussion is needed, it is recommended the individuals step out of the room. In addition, the medical record review room should be near restroom facilities and free of overhead pages. The temperature of the room should be monitored to ensure it is comfortable and conducive for the surveyors to complete the record reviews.

It is acceptable for the trauma program to display abstracts, posters, and other types of program activities in the medical record review room.

The TMD and TPM must have the ability to locate individuals quickly for interviews and to answer questions related to a trauma medical record review. A separate room for individual interviews must be near the medical record review room to complete interviews.

It is strongly recommended that an individual from the facility's engineering or physical plant be available to respond to requests from the medical record review room.

Each surveyor must have an assigned login name, or the navigator must be able to log-in to the EMR and any other programs necessary for the medical record review. IT should ensure the computers utilized for the medical record reviews do not frequently time-out or log out the survey team.

Surveyors must follow the facility's measures regarding HIPAA and how to name or number the medical records being reviewed.

Staff Preparation

All medical record navigators should be available in the room **15 minutes** prior to the medical record review start time. Navigators should practice moving through the various aspects of the closed chart in a practice session with the TMD, TPM, or designee prior to the survey. All staff entering the medical record review room need to understand that noise and conversations should be kept to a minimum. All key individuals need to know the location of the identified interview.

Exit Conference Planning

The facility and trauma program leaders will determine who is invited to the exit conference. Typically, all individuals who participated in the planning and actual designation survey, including all members of the executive team, are invited. The executive team may include members from the Board of Managers. The facility may choose to invite members of their local EMS and RAC to the exit conference. The facility will develop a roster that includes the names and titles of those present at the exit conference. The completed roster is given to the survey team members at the end of the exit conference.

The minimal requirements for attendance at the exit conference include the trauma program's administrator, medical director, and program manager.

Representatives from the media are not allowed to attend the exit conference. Information regarding the trauma designation survey should not be released until the facility has received the department's confirmed designation award and certificate.

Post Survey Activities

If the survey team identifies key documents that need to be submitted to the survey team to assist in validating that a designation requirement or standard is met, these documents must be sent to the lead surveyor within 3 business days of the completion of the survey.

If the facility has 4 or more designation requirements that are not met based on the exit survey findings, the facility must call the department within the next 10 business days to discuss an action plan. This call will include the designation program manager and assigned trauma designation coordinator.

The facility will send the designation survey summary report, medical record reviews, and any additional documents to the department within 90 days of the survey date. If the survey team identifies requirements are not met, the facility must include their POC to address the requirements not met, including the title of the individual responsible for ensuring the corrective actions are implemented, the date the corrective actions are implemented, and define how these actions are tracked and monitored. The corrective actions must be implemented within 90 days of the survey date.

Note: The facility's designation survey application will not be processed until all documents and the designation application fee are received.

Required documents to be sent to the department **within 90 days** of the completed trauma designation survey include:

- Completed or updated trauma designation application.
- Completed DAQ and required attachments.
- Documented trauma designation survey summary report that includes findings of requirements met and not met, and medical record reviews.
- A POC, addressing all designation requirements "not met" that includes the following:
  1. A statement of the cited designation requirement(s) not met.
  2. The defined corrective actions taken by the facility to address the requirement(s) not met.
  3. The title of the individuals responsible for ensuring the corrective actions are implemented, monitored, and tracked.
  4. The date the corrective actions are implemented.
  5. A process of monitoring the corrective actions measured to identify change. It is recommended the progress of the corrective actions be reported at the facility's trauma operations committee to keep the trauma program informed.
  6. Evidence of data validation and quarterly submissions to the State Trauma Registry and NTDB (if applicable) for the past 12 months.
  7. Evidence the facility's trauma program participated at RAC meetings throughout the designation cycle.
  8. Full payment of the non-refundable, non-transferrable designation fee and department remit form submitted to the department Cash Receipts Branch per the designation application instructions. If the remit form or account deposit information is not sent with the payment, the payment will be returned.

Media Communication and Release

As previously stated, media representatives are not included in the facility's site survey or the exit conference of the survey. There are no exceptions. Media releases and communication regarding designation can occur after the facility receives its designation award. Department staff do not participate in media events recognizing the facility's designation award.

If a facility wishes to have a media release regarding its designation, the facility must ensure the correct language is utilized. Survey organizations validate that the designation requirements are met. Only the department can designate a facility. A hospital is not considered designated or redesignated until they receive the signed designation award letter and certificate from the department.

Feedback

Facilities have the right to voice concerns and provide feedback regarding the survey process, surveyor(s), or department if they identify issues related to the survey planning, survey, or survey follow-up. All feedback should be submitted to the EMS/Trauma Systems Section Director. Feedback will be reviewed by the trauma designation review committee.

Recommendations and action plans following the committee review will be the responsibility of the department. See Appendix J Designation Survey Feedback Form.

Consultative Surveys

Facilities seeking designation may choose to have a consultation survey before the actual survey to evaluate their program. A consultative survey may be done as a "mock survey" or as a "peer-to-peer" review. The facility may choose the option of a consultation survey to review specific designation requirements prior to their actual survey or a full survey consultation. It is recommended that these consultative surveys be performed between 24 to 18 months prior to the actual survey date to allow the facility time to review the consultation report, implement recommendations as needed, and have documentation reflecting the history of meeting the designation requirements prior to the designation survey. Consultative surveys are between the facility and the consultant(s). These consultation reports are not included in the designation survey process or required to be shared with the department. All costs associated with the consultation survey are the responsibility of the facility.

DEPARTMENT APPROVED SURVEY ORGANIZATION SURVEY GUIDELINES

Department-Approved Survey Organization

Survey organizations requesting department approval to complete trauma designation surveys in Texas must complete the department application every 4 years. The initial application to be recognized as a department-approved survey organization needs to be completed and sent to the department by September 1, 2025. Subsequently, renewal applications and new applications will be accepted between January 1st and January 31st in the following years. Department-approved survey organizations must complete a new application every 4 years following the same process. See Appendix G Survey Organization Application.

The survey organizations must define their surveyor selection process ensuring they follow the department guidelines and define how these individuals are trained and credentialed to complete trauma designation surveys. The training must include an overview of the specific TAC §157.126 rule requirements for designation and how the surveyor evaluates facility evidence and documentation to validate the requirements and standards are met or not met. This training must include how to complete documentation for the survey organization's survey documents that meet the department's requirements. Each surveyor must have documented evidence of completing a trauma performance improvement course approved by the department.

Surveyors must have led or participated in their facility's trauma designation survey and have two successful trauma designation surveys at their facility. Surveyors must first attend the surveyor training and then observe a designation survey. In this observation role the surveyor in training will complete 3 medical record reviews. The surveyor mentor must complete a review and critique of these medical record reviews. The next step is for the surveyor in training to assist in a designation survey while being mentored by a senior surveyor. The senior surveyor must complete a critique on the surveyor in training's communication skills during the survey, their ability to validate the designation requirements and standards are met, their skills at seeking additional information to validate requirements are met, and completion of the medical record review summary.

Approved surveyors must have evidence of conducting two trauma designation surveys annually to maintain competencies and skills.

The survey organization is responsible for the development of the survey tools they utilize, ensuring these documents meet the department requirements and capture all essential elements of the survey process and TAC requirements. There must be documentation of evidence that each of the designation requirements are met. The medical record review must reflect the phases of trauma care to include:

- activation responses
- consultation responses
- operative interventions and procedures
- days in ICU and consults in the ICU
- interventions and procedures in the ICU
- inpatient admission, interventions, and procedures
- on-going assessments and interventions

- rehabilitation consults and needs assessment
- Screening, Brief Intervention, and Referral to Treatment (SBIRT) screening and interventions
- abuse screening, mental health screening and referrals
- psychosocial interventions
- discharge planning

If the patient is a pediatric trauma patient, the surveyor must document compliance to the pediatric-specific designation requirements.

The documentation must reflect trauma management guidelines are followed. The surveyor must comment on the trauma program's identified performance improvement (PI) events and how they were processed and monitored to event resolution. The surveyor must also comment on PI events or variances in care not identified by the facility. The surveyor must review the timeliness and effectiveness of the PI process regarding the primary, secondary, and tertiary levels of review, and how corrective actions were monitored to demonstrate effectiveness. The surveyor must define if event resolution was obtained and sustained.

The survey organization must have a surveyor oversight and PI process that reviews the accuracy and quality of the survey reports generated by their surveyors. The organization must have measures to evaluate each surveyor's performance for a survey. Each surveyor must complete 10 medical record review summaries that reflect how the designation requirements/standards were met during the survey and complete survey assignments of specific designation requirements/standards requested by the lead surveyor. The surveyor must demonstrate excellent communication skills and good time-management skills during the survey to ensure the survey begins and ends on time.

The department provides feedback regarding the survey report and medical record review summaries to the survey organization. If surveyor concerns are identified, the department shares this information with the survey organization. **It is the survey organization's responsibility** to address issues or concerns with their surveyors. The survey organization must define how this occurs in their survey organization application process. Failure to address or assess a designation requirement, poor or lack of documentation validating requirements are met, incomplete survey reports, time management issues, or unprofessional behavior of a surveyor is not acceptable and must be addressed by the survey organization to remain in good standing as a department-approved survey organization.

Survey Schedule

All initial surveys for designation must be onsite and follow the recommended schedule.

It is the facility's choice for a re-designation survey to be onsite, virtual, or hybrid. The department may determine that an onsite survey is required for a facility based on the previous survey findings of requirements not met.

Surveys for facilities having their third designation review with no previous contingencies and all designation requirements met in the last survey may utilize a one-day survey agenda. The facility and the department-approved survey organization may utilize a hybrid survey. In this model all survey team members are either virtual or onsite.

Examples of a hybrid survey are the survey team virtually meets with the program leaders prior to the survey to fully discuss the program documentation in advance of the scheduled survey. The documentation referred to includes the DAQ and attachments, and all documents loaded into the shared file 45 days prior to the survey. The pre-survey conference call can be extended and utilized to discuss the documents and identify any outstanding items needed. The survey team

reviews these documents in advance to understand the program's resources and capabilities. This allows the survey team to focus on the medical record reviews while onsite. Virtual surveys need to review the electronic medical records (EMRs) and not request the facility to print out documents other than the face sheet, admission H&P, and discharge summary.

The facility planning for a virtual survey will ensure the surveyors and all survey participants have access to the survey platform and are knowledgeable of using system applications, such as how to mute and unmute, share their screen, utilize the chat box, create additional smaller conference rooms, and other features that may be necessary for the survey.

Note: If the facility agrees to a virtual survey with a survey organization, the survey organization may modify the survey schedule. The schedule must not require overtime for facility staff or other unintended consequences.

The schedule must be accepted by the facility CNO, TMD and TPM, trauma administrator, and approved by the department.

The survey organization must have defined measures to continuously maintain patient confidentiality and HIPAA compliance.

Recommended Survey Schedule

The survey schedule is recommended for facilities completing their second designation survey, for facilities that had previous designation contingencies, for initial designations, or for initial designations at a higher level. This schedule reflects a full-day and half-day survey.

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

If the recommended survey schedule is not utilized, the facility must review and approve the survey schedule to ensure there is not an undue burden to the facility. The survey organization must submit the agreed survey schedule to the department for approval prior to the survey.

The facility begins the survey process by placing required documents into the shared file a minimum of 45 days prior to the survey. The surveyors are given access to the shared files to facilitate their review of the documents.

The lead surveyor will make assignments for the survey team to ensure all requirements for designation are reviewed. The lead surveyor is responsible to ensure all surveyors complete their medical record reviews prior to the exit conference. (Required documents are located under "Preparing Survey Documentation" on page 7.)

Pre-Survey Conference Call

The purpose of the pre-survey conference call is to discuss documents placed in the shared file to ensure all necessary documents are received and define the plan for the actual survey. The pre-survey conference call allows the surveyors an opportunity to ask questions and clarify information regarding the documents. The facility will review its improvements and facility enhancements since the last designation survey and review any key staff changes. The surveyors are required to review the medical record face sheets, admission H&P, and discharge summaries, and provide a list of recommendations to the lead surveyor prior to the scheduled pre-survey conference call. The lead surveyor will finalize the medical records selected for review with the facility trauma program staff.

All surveyors are required to review the documents placed in the shared file by the facility prior to the pre-survey conference call.

The lead surveyor will clarify the agenda and any alterations in the survey agenda. The lead surveyor defines the additional items the facility needs to review during the survey opening conference.

Day 1

Survey Opening Conference
The facility's program leaders are responsible for ensuring the reserved conference room for an onsite survey is an appropriately sized conference room, and it must have sufficient internet and electrical support. The conference room must have audio sound to ensure all participants can hear the presentations and questions. This room needs to be free of overhead pages.

The survey is an information-packed event. Each surveyor is expected to arrive prepared and ready to engage with facility staff. Preparation for the survey begins with the review of the facility's DAQ, updated application, and the documents placed in the shared file 45 days before the survey. Surveyors should arrive with their list of questions or items that need further clarification and be prepared to seek clarification from the facility's staff during the opening conference if this was not completed in the pre-survey conference call.

The onsite survey team will arrive at the facility by 0715. The opening conference begins at 0730. The facility's leaders will initiate the opening session. This opening session includes introduction of the facility's staff present, invited participants, and the surveyors. The lead surveyor provides a brief overview of the survey schedule.

Opening Survey Comments
The facility has until 0830 to provide an overview of the facility. The history of the trauma program, and its role in the region is reviewed first.

The surveyors are given a folder that has a copy of the survey schedule, presentations provided, and a list of the individuals participating in all sessions of the survey.

Key issues to cover during this opening conference

1. Survey schedule and timelines.
2. Introduction of the surveyors and facility staff.

3. Key areas of improvement since the last survey, targeting the requirements not met at the last survey and defined weaknesses.
4. Overview of the facility's role in the regional system.
5. Structure of the trauma PIPS plan.
6. 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.
7. Pediatric readiness compliance.
8. 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.
9. Overview of the facility, demonstrating key areas involved in the trauma program and any improvements linked to improved trauma outcomes.

0830 Facility Tour

A facility tour with specific interviews during the facility walk-through assessment will be completed for initial designation reviews or designation reviews for a different level. The purpose of the facility walk-through assessment is for the surveyors to gain an understanding of and evaluate the following:

1. Trauma resuscitation rooms, equipment, resources, staffing, EMS communication, EMS timeout process, wristband number documentation, the helipad and associated staff safety training, and disaster readiness.
2. Flow of the trauma patient population through the facility from the emergency department to radiology, diagnostic imaging such as ultrasound, computed tomography (CT) scan, interventional radiology (IR), Blood Bank, respiratory therapy, and movement to the OR, ICU, or inpatient trauma units.
3. Facility's commitment to providing the required resources and equipment for the care of the trauma patient population.
4. Evaluate that facility's bedside staff readiness to care for the trauma patient population, their knowledge, education, and their role in the trauma program, and PIPS plan.
5. Evaluate specific assigned designation requirements.

0830 Group interviews

When a facility walk-through assessment is completed, group interviews are not needed. Group interviews are utilized for re-designation, virtual, or hybrid surveys.

There will be a physician group interview and a nursing and clinical services continuum of care group interview. The physician group interview includes the lead surveyor, TMD, core surgeons, trauma liaisons, rehabilitation, medical director of the blood bank, the identified required surgical specialties, and the APPs assigned to trauma. Residents and fellows participating in the trauma program are included in the physician group interviews. The CMO, Chief of Staff, or Chair of the Medical Executive Committee also attend this group interview. The facility is encouraged to include the EMS Medical Director in this group discussion.

The nursing and clinical services continuum of care group includes the registered nurse surveyor, trauma administrator, TPM, nursing unit leaders, educators, and staff. The clinical support areas for the laboratory, blood bank, medical imaging, respiratory therapy, rehabilitation (physical therapy

(PT), occupational therapy (OT), Speech therapy), psychosocial support, social services, discharge planning, and other support services attend this group discussion. The CNO and a representative from Quality are included in the nursing group interviews. The purpose of the group interview is to use scenario-based questions to identify the continuum of care, compliance with management guidelines, continuing education, patient support services, and compliance with the designation requirements. The registered nurse surveyor leads this group interview.

In Level IV trauma facilities managing 100 or less patients meeting the NTDB registry inclusion criteria with limited resources, the group interview integrates everyone to include the physicians, nurses, and clinical services. The EMS medical director is invited to this group discussion.

The scenario-based interview questions require planning and preparation to ensure they are organized, pertinent to the facility, and relative to the trauma program's activity and volume, as evidenced in the DAQ. The scenario-based questions for the physician and nursing continuum of care groups should be similar, to evaluate the designation requirements for clinical processes, education, and resources.

See Appendix I for examples of the group interview process.

The surveyors use these group interviews to validate information from documents in the shared file are consistent with how practice is described. The group interviews provide a forum to validate that trauma management guidelines and trauma oversight continues through the continuum of care and meets designation requirements.

Virtual meetings require an adequate platform with stable internet to accommodate the number of participants and scheduling needs. A representative from IT must be available for technology support. The surveyor needs a list of the participants and their titles to facilitate discussion. All participants need to introduce themselves and the area they represent when speaking. In-person meetings require appropriate scheduling, adequate space, and a sound system to support interactions. It is best to have tables in a U-shape with name cards for each individual and a sign-in sheet with the names and titles of those invited and present at the meeting.

0930 Medical Record Review

Most of the survey time is utilized for the medical record reviews. The purpose of the medical record review is to evaluate clinical care provided to the patients, compliance with trauma management guidelines, the effectiveness of the trauma PIPS plan, trauma patient outcomes, and designation requirements. Clinical care is reviewed from pre-arrival or prehospital through discharge planning and follow-up as appropriate. The clinical care, sequencing of care, and timeliness of care provided are assessed through the documentation and captured by the surveyor in the survey medical record review summary. Each phase of care is reviewed to ensure that designation requirements are met, the facility follows established trauma management guidelines, and variances in care are identified. The surveyor must be compliant with all HIPAA measures during the entire survey process.

The surveyor is required to assess the following for each trauma medical record reviewed aligning with the designation requirements.

- Prehospital communication and field triage is appropriate.
- Prehospital administration of whole blood meets established criteria.
- Prehospital care assessment, interventions and timeliness meet patients' needs.
- Trauma team activation guidelines are followed.
- No evidence of under-triage is present.
- Trauma team response meets the established timelines.

- Emergency physician response is appropriate.
- Surgeon response is appropriate for trauma activations.
- Resuscitation guidelines are followed, and the guidelines align with national standards such as Advanced Trauma Life Support (ATLS).
- Trauma management guidelines are followed.
- APPs participating in trauma activation patients' care are current with ATLS.
- Imaging timelines and guidelines are followed.
- Lab response and turnaround times are appropriate.
- Availability of blood as requested meets the facility guidelines.
- Massive Transfusion Protocol (MTP) activations are timely and follow the facility's established guidelines.
- Time-sensitive trauma transfer decision times follow guidelines.
- Transfer coordination is appropriate.
- Receiving facility provides feedback.
- Timeliness and sequencing of care are appropriate.
- Radiology images are read by the radiologist within the established timelines.
- Radiologist response time when requested for imaging reads is appropriate.
- Deep Vein Thrombosis (DVT) prophylaxis guidelines are followed.
- Orthopedic trauma management guidelines are followed.
- Orthopedics is present at bedside within 30 minutes of request for those patients who meet criteria or transfer is initiated if orthopedics has defined the care exceeds the facility's capabilities.
- Neurosurgery trauma management guidelines are followed.
- Neurosurgery is present at bedside within 30 minutes of request for those patients who meet criteria or transfer is initiated if neurosurgery has defined the care exceeds the facility's capabilities.
- Pediatric trauma management guidelines are followed.
- Complete pediatric vital signs and weight in kilograms (Kg) are recorded.
- Imaging as low as reasonably achievable (ALARA) guidelines are followed for pediatric patients.
- Obstetric (OB) trauma management guidelines are followed.
- Burn management and transfer guidelines are followed.
- Reassessment expectations are followed.
- Pain management guidelines are followed.
- If admitted to the OR, OR response is timely and meets requirements.
- If operative intervention occurs, admission post operative assessments are appropriate.
- If admitted to the ICU, the admission assessment is completed timely, and the patient meets the ICU admission criteria.
- If admitted to inpatient unit, admission assessment is completed, and trauma injuries are assessed timely.
- Completion of the tertiary exam follows facility guidelines.
- Inpatient trauma specialty consults are completed in a timely manner and meets established guidelines.
- Ongoing assessments for trauma injuries are appropriate.

- Inpatient continuum of care follows the established trauma management guidelines.
- Inpatient documentation of ongoing trauma injury assessments is appropriate.
- Needs for rehabilitation are assessed.
- SBIRT screening is completed for admitted trauma patients greater than 12 years of age.
- SBIRT interventions or referrals are provided if patient screens SBIRT positive.
- Abuse screening is completed, and referrals are completed following established guidelines.
- Mental health screening and referrals are completed following established guidelines.
- Psychosocial support is available.
- Documentation reflects the trauma program and trauma physician have oversight of the trauma patients.
- Discharge planning for trauma injuries and overall patient status is appropriate.

The survey organization is responsible to develop a survey medical record review summary document. The surveyor's documentation must reflect the trauma care provided from the medical record review and define if trauma management guidelines were followed, and trauma designation requirements were met. The department-approved survey organization is expected to have medical record review forms that capture the information listed below. The survey organization can define the format their surveyors will utilize ensuring all documentation requirements are met. The form can be adjusted for various levels of trauma designation and requirements.

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.	
• 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	
• 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	
• 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	
• Surveyors summary of case • Recommendations	

The medical record review includes the surveyor's review of the trauma PIPS initiatives. This includes the identification of variances in care or variances in system response events, level of

harm produced by the event, levels of review, corrective actions taken, and measures to reach and sustain event resolution. As each medical record is reviewed, the surveyor must have the file that contains the trauma PI documentation for that specific case, minutes from committee meetings or conferences of the case review, any follow-up documentation, registry data profiles, and associated management guidelines specific to the case.

The surveyor is responsible to identify the following issues from the medical record review and include the findings in the medical record review document.

- Identified facility events and variances in care or the system are managed through the trauma PI process.
- Primary level of PI review is completed no later than 14 days after the patient's discharge.
- Identified events and variances have the level of harm identified, are processed through levels of review, and meet the expectations outlined in the facility's trauma PIPS plan.
- Documentation of the TMD's secondary level of review including date.
- Corrective actions are developed and implemented for identified events or variances in care or system performance with opportunities for improvement.
- Corrective actions are implemented and monitored, data is available for review, and the desired change is documented.
- Event resolution is documented for each event or variance identified.
- 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, and the identified opportunities for improvement.
- Trauma registry data abstraction for the medical record being reviewed is accurate regarding procedures, injuries defined, and phases of care.
- Trauma ISS calculation is accurate.
- If the case is a mortality, there is documented evidence of a mortality review through the trauma PI process.
- Autopsies for mortalities are available for review. Injuries are listed and congruent with the trauma registry data.
- Mortality is categorized utilizing the terminology outlined in §157.126.
- Evidence that events identified as "regional opportunities for improvement" are referred to the identified provider and the regional performance improvement process for tracking.

The surveyor's PIPS review reflects the facility's trauma PIPS plan is followed and is effective.

Documented evidence that any PI referral sent has follow-up to event resolution.

Transfer follow-up letters and autopsy reports, as available, are also reviewed at the time of the medical record reviews.

Surveyors cannot accept verbal comments by the facility's team. Surveyors must review the actual documents to define timelines and sequencing of activities.

The surveyor will identify any outstanding medical record issues and inform the assigned navigator. Navigators share this information with the TMD and TPM. This provides the facitlity with an opportunity to provide the needed documentation. This also ensures the program is aware of these issues and, when possible, resolves the issue by the end of the survey day.

The assigned navigator for the surveyor is responsible for the flow through the medical record,

allowing the surveyor time to read, evaluate, and find specific elements of care, which often includes times notified or consulted and time of response, specific times of transitions in care, or other pertinent events and diagnostic studies. In addition, the assigned navigator must be familiar with the trauma program's PI process and documents. The navigator must be able to explain documentation requirements, management guidelines, and questions related to the PI activities.

In each phase of care, the surveyor is expected to determine if the facility's documented management guidelines were followed, if the facility's trauma policies, procedures, and protocols were followed, and if the designation requirements were met. If the facility identified any variances in care or events, the surveyor must review all associated trauma PI documents. If the surveyor identifies variances in care not identified by the facility, the surveyor will document this in the medical record review summary and share the information with their assigned navigator. The navigator is responsible for sharing this information with the TMD and TPM.

Lunch (≈1200 to 1230)
The survey team and designation staff will break for lunch for approximately 30 minutes. This needs to be a private lunch to facilitate surveyor discussion. The survey team will share their findings and define any issues that need follow-up or further clarification.

The lead surveyor will request time with the trauma program administrator, TMD, and TPM at the end of lunch to share the current findings. This allows the facility to address issues as appropriate.

Facility staff should also have lunch during this time to ensure the survey can continue without interruption.

1230 Medical Record Review Continues
The medical record review will continue until ≈1630.

1630 Closed Survey Team Discussion
This is a closed meeting held in the medical record review room. Surveyors and the designation staff attend this meeting. This is dedicated time for the survey team to begin completing the designation requirements checklist and to continue to compare any issues of concern or follow-up. A list of potential requirements not met, potential opportunities for improvement, regional participation, observed best practices, and strengths are generated to share with the trauma program administrator, TMD and TPM.

The survey team will define the number of outstanding medical records that need to be completed and any outstanding survey issues. The surveyors will define a plan to complete the survey the following day.

1700 Update
The survey team will provide an update to the trauma program administrator, TMD and TPM. The update defines the potential requirements not met and what is needed to validate requirements are met. The survey team shares the list of opportunities for improvement, regional participation, observed best practices and the strengths of the program.

The site survey timelines may vary based on the survey readiness, medical record reviews, and unanticipated events that occur during the survey. The lead surveyor is responsible for adjusting the schedule and notifying the trauma program leaders. The program staff is responsible for communicating the change in time to all individuals who need to know.

The survey team will define the expectations for the following day, focusing on what is needed to complete the survey.

Day 2

0715 to 0930
Medical Record Review Continues
Surveyors must complete the 10 medical record reviews.

Specific Interviews
The survey team will complete any outstanding interviews necessary.

Completion of Document Review
The survey team will complete any outstanding document reviews. This includes any information requested by surveyors based on the previous discussions and the medical record reviews. Surveyors are expected to review the documentation specific to their lead surveyor's assignment. An example is outreach education. The assigned surveyor will review all documentation related to outreach education and will be prepared to provide documentation that the outreach education requirement is met by evidence of or not met by evidence of…. The surveyor begins their assignment reviews once the files are placed in the shared file 45 days prior to the survey and may continue the review through the designations survey.

Closed Surveyor Team Meeting 0930 to 1030
The survey team will prepare their closing remarks. The team will define any potential requirements not met, opportunities for improvement, regional participation, observed best practices, and strengths Each potential requirement not met must have a defined recommendation. The lead surveyor is responsible for ensuring the designation requirements checklist is completed. The lead surveyor will define the items to cover in the exit conference and which surveyor is responsible for delivering that information.

1030 to 1100 Exit Conference
The lead surveyor will thank the facility for the opportunity to review their program.

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.

The lead surveyor and survey team will review the following:

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

The exit survey conference is open to all facility staff, depending on the room size. **The following members are required to attend the exit conference**:

- Trauma medical director
- Trauma program manager
- Trauma program administrator

Representatives of the media are not allowed to attend the exit conference.

Adjournment

Once the survey team has completed the review of the survey findings, the survey is complete. The survey team will thank the trauma program and leaders for their time and commitment to trauma care and exit the facility.

Designation is determined and awarded by the department. When available, the department staff will comment on the review of the application and turnaround time, or any next steps that need to be taken.

The facility's program staff are responsible for assigning an individual to escort the survey team to the exit, as necessary.

Post-Survey Actions

Survey Team

The lead physician surveyor is responsible for compiling and collating the survey report. The lead surveyor is responsible for ensuring the report captures all issues and reflects the review of all designation requirements. Issues identified in the medical record reviews and trauma PIPS reviews need to be integrated into the survey report.

The survey team may choose to make a list of the medical records reviewed and list requirements not met, sequencing and timeliness of care, compliance with trauma management guidelines, identified issues with the continuum of care, documentation, timeliness of transfer, and issues related to the trauma PI process, or trauma registry data abstraction, and ISS calculations This will assist in integrating the medical record findings into the survey summary report.

If the survey team requests any specific documents from the facility to validate that a requirement is met, the document must be received by the lead surveyor within 3 business days of completing the designation survey. The survey report will reflect when these documents were received and if the documentation validates the requirement is met.

The surveyors send the survey summary report and medical record reviews to the survey organization. The completed survey summary report and medical record reviews are sent to the facility within 30 days of the survey date. The survey organization is responsible for reviewing the accuracy, completeness, quality of the survey summary report, and medical record reviews to ensure consistency of the survey summary reports.

Survey Organization Performance Improvement Process

The survey organization must have an established performance improvement process to review its survey process. Elements of the survey process performance improvement reviews include the following:

1. Surveyor meets the defined requirements and expectations.
2. Surveyor completed the required training and credentialing.

3. Surveyor completes an intern survey with an assigned mentor.
4. Surveyor completes 2 surveys annually.
5. Surveyor documentation in the designation survey summary report provides evidence the requirements are met or not met.
6. Surveyor documentation in the designation survey summary report reflects when requirements are not met and links this back to associated medical record reviews when appropriate.
7. Surveyor documentation adequately reflects information reviewed and identified in the medical record reviews.
8. Surveyors are required to complete a trauma performance improvement course approved by the department.
9. Surveyors are required to maintain identified certifications specific to their role.
10. Surveyors are required to complete any department training updates as new rules or survey guidelines are introduced.

The physician lead surveyor requires the ability to collate information from all the surveyors' documentation to develop a concise reflection of the survey summary. The designation survey summary report must define requirements not met, opportunities for improvement, regional participation, observed best practices, program strengths and recommendations for each requirement not met. The survey organization is responsible for developing a survey summary report that includes a table of the following findings. An example is below.

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
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

When the survey organization's PI process or the department identifies opportunities for improvement regarding a surveyor or survey summary report, the survey organization must have documentation and evidence that reflects how these opportunities are addressed.

Surveyor Expectations

Surveyors must complete site surveyor training for trauma designation surveys through a department-approved survey organization. The survey organization is required to prepare surveyors for the trauma surveys and to ensure surveyors are consistently following the trauma designation survey guidelines.

All current surveyors for approved trauma facility survey organizations must complete the surveyor training and meet the surveyor requirements. Surveyors must have evidence they have completed a trauma performance improvement course approved by the department, and they have led their facility through 2 successful trauma designation surveys. Surveyors must attend the DSHS trauma surveyor training and complete a minimum of 2 surveys annually. These surveyors must be in good standing with the survey-organizations' review of their survey performance.

Level I, II, III and Level IV facilities managing 101 or more patients meeting NTDB registry inclusion criteria are reviewed by surveyors that are currently employed in a designated trauma facility at the same or higher level of designation. Surveyors are TMDs, trauma surgeons, trauma liaisons, or TPMs/directors, with current trauma nursing certifications.

Level IV trauma facilities managing 100 or less trauma patients that meet the NTDB registry inclusion criteria are reviewed by surveyors that are currently employed in a designated program at the same or higher level of designation or surveyors that have 5 years or more of experience in oversight of a trauma program. Physicians who meet the 5 years of experience requirement and continue to be employed in a hospital are required to be board certified. Physicians meeting the 5 years of experience in oversight of a designated program must maintain a current board-certification, ATLS verification, and 8 hours of CME annually. Registered Nurse surveyors meeting the 5 years of experience in oversight of a designated trauma program must maintain their Advanced Trauma Course for Nurses (ATCN) or Trauma Nurse Core Course (TNCC) and Emergency Nurse Pediatric Course (ENPC) or Pediatric Advanced Life Support (PALS) certification and maintain 8 hours of trauma related continuing education annually.

Individuals hired by department-approved survey organizations that have 10 years of experience with oversight of a trauma program and maintain their board certification or required certifications qualify as surveyors. These individuals must maintain 8 hours of trauma continuing medical education (CME) or continuing nursing education (CNE) annually. These individuals can survey facilities at the same level where they provided oversight and any lower-level designated facility. These individuals can be a full-time or part-time employee.

Surveyors are required to complete a department trauma facility surveyor training module prior to completing surveys after September 1, 2025. Surveyors are required to meet the requirement outlined in TAC §157.126 regarding the conflict-of-interest for each survey they are assigned and complete.

Individuals interested in surveying will complete an application for the department-approved survey organization for consideration. If selected by the survey organization, the surveyor will complete the survey organization's training course. The survey organization is required to keep records of surveyor training and credentials and to ensure surveyors complete the department trauma facility surveyor training module prior to being assigned a trauma survey after September 1, 2025.

Trauma facility surveyors are required to attend DSHS surveyor updates when new rules or survey guidelines are introduced.

A key element of surveyor training is to monitor a survey with an assigned surveyor mentor. In this capacity, the individual training to be a surveyor is expected to review at least 3 medical records,

complete the medical record review summaries, and participate in the series of survey questions lead by the experienced surveyor. The surveyor mentor assigned to the new surveyor critiques their performance at the end of the survey. The critique form is developed by and retained by the survey organization. If the surveyor mentor signs off that the surveyor expectations are met, the next step for the new surveyor is to serve as a survey team member and be monitored by the lead surveyor. Physician surveyors will mentor the new physician surveyors. Nurse surveyors will mentor the new nurse surveyors.

Surveyor Requirements

1. Experience in leading a facility through 2 successful designation surveys (surveys resulting in a contingent or probationary designation do not meet this requirement).
2. The lead physician is in a lead role in their trauma program as a medical director or trauma surgeon, board-certified, actively participating in clinical care in their trauma program, and in the PIPS process.
3. Other physician surveyors must be active as a trauma liaison and participate in their trauma program's PIPS processes.
4. The nurse surveyor is a TPM that is actively participating in the clinical care oversight of their trauma program, including the oversight of the PIPS process and outcome reviews.
5. Surveyors outside of Texas must be from the same or higher level of verified/designated facility and their facility has had 2 successful designation surveys.
6. Individuals who are not employed by a designated trauma facility must meet the trauma expertise requirements of 5 years of trauma program oversight, current required certification, and 8 hours of CME/CNEs annually. Physicians must maintain board-certification.
7. Individuals who are employed by a survey organization must have evidence of 10 years of experience in the roles required to be a surveyor prior to employment at the survey organization and maintain board certification, required certifications, and 8 hours of CME/CNEs annually.
8. Emergency Medicine Physicians must have a minimum of 5 years of experience in the role of a program liaison, actively participating in the designated program, and be board-certified.
9. Surgeon and nurse surveyors must have completed a PIPS course in the last 4 years and not received any weakness or requirements not met related to PIPS in their facility's site survey.
10. In-state surveyors attend and participate in the GETAC.
11. Must have documented evidence of completing the survey organization's surveyor training course.
12. Must complete a successful intern survey with an assigned surveyor mentor that completes a critique at the end of the survey.
13. Must complete a minimum of 2 surveys annually to remain current.
14. Must maintain an annual conflict of interest statement with the survey organization and disclose if there is any potential survey conflict of interest or concern before accepting an assigned survey.
15. 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.

16. Must always maintain a professional relationship during the survey.

Surveyor Orientation

Each surveyor must attend the training and orientation outlined by the department-approved survey organization. These training programs are critical to the surveyor's success and introduce the role of the surveyor and the Texas expectations for surveyors. The training, orientation, mentorship survey, and this guide assist in developing consistency in the survey process.

The surveyor training will define the following processes:

1. Authority, responsibility, and operations of DSHS specific to the trauma designation process.
2. Expectations of the survey organization.
3. Survey team roles and expectations.
4. Expectations for a completed survey.
5. Standardized expectations such as the review of the designation program's oversight, management guidelines, PIPS plan and processes, registry process or data management, outcome reviews, and outreach activities.
6. Validating that all designation requirements are met.
7. Identifying and defining requirements not met, opportunities for improvement, regional participation, observed best practices, program strengths, and providing pertinent recommendations for each requirement not met.
8. Expectations and timelines for completing the written survey summary report.
9. Time management skills for completing 10 medical record reviews and summaries.

Professionalism
All surveyors must continuously maintain professional behavior. If surveyors are having issues during the survey process, they must discuss the issues with the lead surveyor for guidance. If this escalates, the department staff representative has the authority to address the issue. If department staff is not present, the lead surveyor must contact their survey organization.

Surveyor Scheduling
The survey organization defines its process for scheduling trauma designation surveys. Surveyors cannot review a facility in their Trauma Service Areas (TSA) Regional Advisory Council (RAC) or a contiguous RAC, a facility that is part of their facility's system, or a facility they have provided designation assistance or participated as a designation surveyor in the past 4 years. In addition, a surveyor cannot survey a facility for which they have had a business relationship within the past 4 years, including previous employment, previous contract relationships, or completion of a residency program. If the surveyor or facility believes there is a potential for a conflict of interest, they are obligated to notify the survey organization. The survey organization is expected to reschedule surveyors if a potential or known conflict exists.

Note: The survey organization is expected to have each surveyor complete a conflict of interest statement for each facility they are surveying and to keep this document on file until the facility has received its designation award from the state.

Confidentiality and Surveyor Expectations
The department requires the survey organizations to maintain confidentiality of all facility surveys and all information gained during the survey process.

Surveyors must be compliant with the following:

1. Avoid discussing information related to the survey of a facility with anyone other than the facility, survey team, survey organization's survey PI process, or the department once the survey is complete.
2. Avoid discussing or sharing the name or referring to any facility you have surveyed in response to questions.
3. Always ask clarifying questions to obtain evidence designation requirements are met and physically review data or documents. Do not make assumptions about processes or facility practices or just accept the facility's answers.
4. Engage with the facility's staff to address any unclear patient care practices you need more information about or information you cannot find in the medical record. Ask these questions while you are reviewing the record. These questions are directed to the assigned navigator, TMD, or TPM.
5. Avoid making unnecessary comments, rendering personal opinions, or statements of "this is how we do it."
6. Clarify the facility's management guideline(s) and the date developed. If there is a concern about the guideline, the guideline has outdated practices, processes are not followed, equipment utilization is unclear, or documentation is lacking, ask the navigator, TMD, or TPM to clarify at that time. Provide the facility an opportunity to address concerns. Ask if the issue was identified in the trauma PI process.
7. Manage your time to ensure you can successfully complete a minimum of 10 medical record reviews during the survey process and the other survey tasks assigned to you by the lead surveyor.
8. Ensure you review all essential information related to the medical record review, PIPS review and outcomes, associated PI minutes, required education of staff, data management captured from the case, and all associated documentation while you are reviewing the medical record to ensure accuracy and completion of the medical record review.
9. If a variance in care or the system is identified, review the associated PIPS documentation to identify how it was managed. If the documentation is not in your medical record file, ask for it at that time, not later during the survey, to avoid unnecessary delays.
10. When reviewing the PIPS documentation, it is important to identify variances in care related to the system or clinical care, management guidelines, complications, and death. For the identified variances or events, review documentation for evidence of the identified level of harm, date of the primary, secondary, and tertiary levels of review, identified opportunity for improvement, defined corrective actions, and how the corrective actions were monitored to create the needed change and event resolution.
11. Once you have completed the facility review and medical record reviews, you will complete a summary narrative that describes the overall facility's leadership, overall review of the clinical care provided by the facility, overall documentation of care, and overall summary of PIPS. This includes identifying any facility or equipment issues that are outdated or do not meet the designation requirements.
12. Surveyors will document objective findings of the survey and not ask program leaders "how can we help you" or "what do you need". The survey process will identify and address these issues.
13. Be professional at all times.

Designation Survey - Surveyor Expectations
The purpose of the designation survey and the objective of the survey team is to validate that the facility demonstrates the designation requirements are met. Surveyors must review documents, assess resources available, interview staff, complete medical record reviews, and define regional integration and participation to validate that requirements are met.

Pre-Survey Conference Call
The surveyor(s) are expected to review the DAQ, the facility's data, and documents prepared and available in the defined shared file 45 days prior to the survey to be prepared for the pre-survey conference call and survey.

The lead surveyor and the program staff will schedule a call a minimum of 20 days prior to the survey. The surveyor(s) will focus on their survey sections assigned by the lead surveyor. Each surveyor will ask any clarifying questions and request any additional documents needed to validate designation requirements are met during the pre-survey conference call.

The lead surveyor and survey team will select and finalize the medical records for the review process during this pre-survey conference call. This decision is facilitated by reviewing the medical record face sheet, admission H&P, and discharge summary, which are included in the shared file 45 days prior to the survey. These documents provide insight into the complexity of patient care and allow a variety of medical record selections.

The medical records must be prepared for the surveyor's review a minimum of 5 days prior to the survey. A file with the PIPS documents, trauma management guidelines, transfer records, autopsy, and other pertinent documents associated with each medical record selected is prepared and added to the shared file a minimum of 5 days prior to the review.

Note: The facility will decide if the medical record review will be completed electronically. Electronic reviews can be completed in the onsite and virtual reviews. Electronic reviews prevent the unnecessary burden of printing out and organizing medical records. If the survey is onsite, these files are prepared and available in the medical record review room on the days of the survey.

Survey Opening Conference
Surveyors must be prepared to engage in the survey opening conference. Again, this requires reviewing the information in the shared file prior to the survey. The purpose of the survey opening conference includes the following:

1. Introduction of the facility staff and surveyors
2. Review survey schedule and timelines
3. Review key areas of improvement since the last survey, targeting the requirements not met at the last survey and defined weaknesses
4. Provide an overview of the facility's role in the regional system
5. Review the structure of the trauma PIPS plan
6. Review the program's trauma performance dashboard
7. Review the disaster preparedness and planning activities
8. Provide an overview of the facility, demonstrating key areas involved in the trauma program (optional)

Facility Walk-Through vs. Virtual Tour Assessment
In onsite surveys, the lead surveyor will define if group interviews and/or the facility walk-through

assessment will be utilized to gain pertinent survey information. In most cases, the lead surveyor will make assignments for the walk-through review during the pre-survey conference call with the facility. Surveyors need to be prepared with their questions specific to the level of designation and designation requirements.

The surveyor(s) will view the virtual tour provided and ask questions specific to their assigned areas.

Facility walk-through assessments are required on initial designations to evaluate the facility. See Appendix H for Examples of the Facility Walk-Through Assessment Question and Evaluation.

Group Interviews
The scenario-based questions utilized for group interviews require planning and preparation to ensure they are organized, pertinent, and relative to the designation program's activity, volume, and geographic location as evidenced in the DAQ. The scenario-based questions for the physician and continuum of care staff should be similar, to evaluate clinical processes and resources available. This allows the surveyors to compare findings at the first closed surveyor meeting. See Appendix I for examples of the group interview process.

Medical Record Review
The medical record review provides a window to review the care provided by the trauma program. Each surveyor must complete 10 medical record reviews and complete a medical record review summary tool for each record reviewed. Surveyors will review the program's PIPS documentation for events identified by the facility while they review the medical record.

The surveyor will focus on the pertinent information related to the patient's care, including:

- timeliness and coordination of care
- compliance to management guidelines
- clinical care and clinical decisions
- continuum of care through to discharge or transfer
- patient handoff, communication
- documentation
- trauma designation requirements

The surveyor reviews the care provided in detail, including the times, responses, who was involved, consultant activity, and patient status. If variances in care or opportunities for improvement are identified, the surveyor must review the PI process documentation to validate the events were identified by the facility, the level of harm or impact to the patient was documented, the levels of review are complete, opportunities for improvement are identified, the defined corrective action plan(s), and the processes to achieve event resolution as defined in the program's implemented PIPS Plan.

PIPS Elements of Review

1. Event identification and date of identification.
2. Impact of the event – level of harm.
3. Levels of review – level (primary, secondary, tertiary, regional), date of review, review included in trauma operations or multidisciplinary peer review committee.
4. Committee case discussions and minutes.

5. Defined opportunities for improvement.
6. PIPS corrective actions.
7. Monitoring of the action plan and changes produced.
8. Event resolution.

In all cases of death (including patients who are made do not resuscitate (DNR) while in the hospital or moved to comfort care), all cases with an identified moderate level of harm or higher, and near-miss events with the potential for a moderate level of harm or higher, the surveyor must review the PIPS processes, corrective actions, associated minutes, opportunity for improvement, and data from the corrective actions utilized to determine event resolution.

Note: These reviews can never have a punitive or judgmental tone. The review must be objective, fact-based, and focus on the concept of a continuous learning environment.

If telemedicine services are utilized by the facility, the surveyor will review the time the telemedicine request or consultation was initiated, when the telemedicine service responded, documentation of the telemedicine service, and if the documented management guidelines were followed. The surveyor will document in the medical record summary when telemedicine services are utilized, their response times, and if appropriate documentation is present.

After each phase of care, the surveyor will define if the facility management guidelines were followed, if resources required for patient care were available, if coordination and continuum of care needs were provided, if documentation met the standards, and if the oversight of the designation program was evident.

The surveyor is responsible to include issues identified in the medical record reviews are included in the survey summary report and that the lead surveyor is aware of all issues. This produces a consistent, validated report.

Closed Surveyor Team Meetings

The closed surveyor conference is designed to provide a private environment for the survey team and department staff to discuss the overall review of the program. Only the survey team members and department staff attend this meeting. It is important that each surveyor be prepared to discuss their survey findings and define additional information required to validate requirements are met. If the surveyor asked for additional information from the program staff during the documentation or medical record review, the surveyor needs to complete the review of those requested documents. If the surveyors identify a program best practice, surveyors will include the information in the exit conference summary and summary report.

The lead surveyor will define the surveyor expectations for the survey summary report, the documentation of the medical record reviews, and the timeline for submitting their assignments to the lead surveyor to facilitate completion of the survey summary report. (In most cases, the surveyors have 10 days to complete their assignments and medical record reviews and forward them to the lead surveyor.)

The surveyors will complete their assigned section of the Texas designation requirements checklist and update the lead surveyor.

The lead surveyor will assign elements of the exit conference agenda to each surveyor. Each surveyor will deliver the information assigned and provide examples for each area when needed. The surveyor needs to be concise when delivering their statements and not ramble or provide information that is not pertinent to their task.

Exit Conference
The agenda for the exit conference typically follows the listed topics:

Topic	***Assigned***
Reading the survey validation statement	Lead surveyor
Requirements not met	Lead surveyor
Opportunities for improvement	Assigned surveyor
Regional Participation	Assigned surveyor
Observed best practices	Assigned surveyor
Program strengths	Assigned surveyor
Recommendations to address the requirements not met	Lead surveyor
Next steps	DSHS Designation Coordinator or lead surveyor.

Examples of Lead in Summary Comments

"The commitment of the institution and the institution's Board of Directors, administration, leadership, medical, nursing, and all staff to support the trauma program is…"
"The capacity to care for XXXX patients from admission through the continuum of care is…"
"The attending physicians' level of engagement and participation in therapeutic decisions and presence is…"
"The specialty physician participation in clinical decisions is…"
"The nursing leadership is committed to excellence in the care of…"
"Use of evidence-based practice is…"
"The commitment to your community…"

The lead surveyor will thank the trauma medical director, trauma program manager, navigators, administrators, surgeons, physicians, and the facility staff for their hospitality and commitment to their community for their pursuit of trauma verification/designation and then read the survey validation statement.

Survey Validation Statement

The lead surveyor will read the following statement:

The survey team has completed your trauma designation survey. Based on the review, we will share our survey findings beginning with the potential designation requirements not met, opportunities for improvement, regional participation, observed best practices, and strengths of the program. We will provide you with our recommendations to address the requirement(s) not met.

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 a designation survey summary report and forward the report and all medical record reviews to the facility's trauma medical director and trauma program manager within 30 days of the survey.

The facility is responsible for submitting the trauma designation survey summary report, medical record reviews, and all necessary documents to the department.

Survey Summary Report

Each surveyor will complete their sections of the trauma designation survey summary report and

forward the documents to the lead surveyor within the timeline established. The lead surveyor will complete the survey summary report to ensure all issues identified by the surveyors are integrated into the final report.

The lead surveyor is responsible for having the survey summary report to the survey organization within the timelines established.

DEPARTMENT DESIGNATION SURVEY FOLLOW-UP ACTIONS

Department Review

The department will review the facility's trauma designation application, and all documents received. The department validates that requirements are met to determine designation status.

If all requirements are met, the department will email the designation award letter and certificate to the facility CEO, TMD, and TPM.

A facility that has 1-3 designation requirements not met, after the department's review of their designation application documents, will receive a contingent designation. The department may schedule a follow-up with the facility to review the requirements not met and the department corrective action plan (CAP).

A facility that has 4 or more designation requirements not met, after the department's review, will receive a contingent probationary designation or designation at the level where the facility meets the designation requirements. The department will follow-up with the facility to review the requirements not met and the department corrective action plan if a contingent probationary designation is awarded. The department will follow-up with the facility's leadership, TMD and TPM, if a facility is designated at a lower level than requested.

The goal is to complete the facility application review and process the designation application within 30 days of receiving a complete application including the fee. Any designation with department identified requirements not met, requires additional time due to facility follow-up.

The designation certificate must be displayed in a public area in the facility as defined in the specific designation rule.

Designation Survey Corrective Action Plans

A department corrective action plan (CAP) is developed for facilities with requirements not met that are designated as contingent or contingent probationary.

For 1-3 requirements not met, the department CAP will require the facility to submit evidence of meeting requirements which may be specific reports, data, or completed education and training. Based on the requirements not met, a focused survey may be required.

If 4 or more requirements are not met, the facility will receive a CAP that requires a focused or full designation survey within 12-18 months from the original survey date. The focused or full designation survey findings must define that designation requirements are met to remove the contingent or contingent probationary status. If the facility is unable to meet the defined requirements or has additional findings of requirements not met, the facility may have its designation level changed to the level where designation requirements are met, or have their designation suspended or revoked.

Appeal Process

Facilities that disagree with the department's designation award may appeal the designation. The facility must electronically submit a written appeal request to the EMS Trauma Systems Section

Director no later than 30 days after receiving their designation letter and certificate. The department will notify the facility of receipt of the appeal request.

Trauma designation appeals are reviewed by the Designation Review Committee defined by TAC §157.126(s)(1)(A)-(C). The committee review is closed and confidential. The department prepares the facility's trauma designation application for the committee's review by blinding the documents and removing identifiers. If the committee upholds the department's designation award, the facility is notified.

If the facility requests a second level of appeal, they must submit a written, electronic request within 15 days after receiving the first level of appeal decision.

The second level of appeal is reviewed by the Consumer Protection Division's Deputy Commissioner. The Deputy Commissioner reviews the appeal request and the facility's designation survey application and defines the designation level for the facility. Trauma facilities can request a hearing in accordance with the department's rules for contested cases and Texas Government Code, Chapter 2001.

Summary

These designation survey guidelines define the processes and expectations for the trauma designation surveys in Texas. The guidelines are designed to assist facilities in preparing for the designation survey. The guidelines outline the expectations for the department-approved survey organizations and surveyors. These guidelines create a common understanding of what is expected during the designation survey process and the potential outcomes of the survey.

Submit questions specific to the trauma designation survey guidelines to DSHS.EMS-TRAUMA@dshs.texas.gov.

EMS Trauma Systems Designation Unit

Website Information

Texas Department of State Health Services

EMS Trauma Systems

Trauma Designation

Staff Contact Information

Designation Unit Email Address:
DSHS.EMS-TRAUMA@dshs.texas.gov

Jorie Klein, MSN, MHA, BSN, RN
Director
Jorie.Klein@dshs.texas.gov
Phone: 512-535-8538

Audrey Green, BSN, RN
Trauma/Stroke Designation Coordinator
Audrey.Green@dshs.texas.gov
Phone: 512-605-9108

Elizabeth Stevenson, BSN, RN
Designation Unit Manager
Elizabeth.Stevenson@dshs.texas.gov
Phone: 512-284-1132

Katie Foarde, MSN, RN
Trauma/Stroke Designation Coordinator
Katie.Foarde@dshs.texas.gov
Phone: 737-354-1849

Rebecca Wright
Designation Program Specialist
Rebecca.Wright@dshs.texas.gov
Phone: 512-657-0804

APPENDICES

APPENDIX A: DEPARTMENT OF STATE HEALTH SERVICES SURVEY ORGANIZATIONS BY DESIGNATION

APPENDIX B: COMMON SCREENING EVENTS/PIPS EVENTS

APPENDIX C: REGISTRY AND DATA MANAGEMENT PROCESS

APPENDIX D: OUTREACH EDUCATION, PREVENTION, PUBLICATIONS, RESEARCH

APPENDIX E. REQUIRED DOCUMENTS, MEDICAL RECORD REVIEW PLANNING AND MEDICAL RECORD FACE SHEET

APPENDIX F: CONFLICT OF INTEREST DOCUMENT

APPENDIX G: SURVEY ORGANIZATION APPLICATION APPENDIX H: FACILITY WALK-THROUGH REVIEW GUIDELINES APPENDIX I: EXAMPLES OF GROUP INTERVIEW

APPENDIX J: DESIGNATION SURVEY FEEDBACK FORM

APPENDIX K: STAFFING CONSIDERATIONS

APPENDIX A: DEPARTMENT OF STATE HEALTH SERVICES APPROVED SURVEY ORGANIZATIONS

American College of Surgeons (ACS)

Website Information

General Information:
Trauma | ACS (facs.org)

Request a Trauma Site Visit:
The Verification, Review, and Consultation Process | ACS (facs.org)

Contact Information

cotvrc@facs.org

Approved to Survey

Comprehensive (Level I)
Major (Level II)
Advanced (Level III)

Texas EMS Trauma & Acute Care Foundation (TETAF)

Website Information

General Trauma Survey Information:
Trauma Survey Services – TETAF

Request a Trauma Survey:
Trauma Survey Request - TETAF

Contact Information:

TETAF Main Line – 512-524-2892

Extension 1
Trauma Survey Scheduling (Aaron Rogers)

Extension 2
Trauma Program Support, including clinical and criteria questions (Terri Rowden)

Approved to Survey

Advanced (Level III)
Basic (Level IV)

APPENDIX B: COMMON SCREENING EVENTS/ PIPS EVENTS

Trauma Required Screening Events

Care provided to patients meeting trauma activation criteria or NTDB criteria is reviewed for variances in the trauma management guidelines, system response, complications, mortality, and designation requirements validation. Identified variances are called events. When an event is identified, the impact of the event or level of harm is defined and documented. The event documentation is reviewed through the primary, secondary, and tertiary levels of review to identify opportunities for improvement and corrective actions. The corrective actions must be monitored until the desired change is met and sustained. These processes are defined in the facility's trauma performance improvement patient safety (PIPS) plan.

Required Screening Events for Trauma PIPS	Level I	Level II	Level III	Level IV
All Levels				
Trauma Medical Director and Trauma Program Manager participate in their local regional trauma advisory council	X	X	X	X
Trauma Medical Director and Trauma Program Manager participate in the regional and facility's mass casualty planning and preparedness	X	X	X	X
Compliance with prehospital triage criteria as defined by regional or EMS Medical Director protocols is appropriate.	X	X	X	X
If prehospital whole blood is administered, criteria are met, and communication is appropriate.	X	X	X	X
Delays or adverse events associated with prehospital trauma care occurred.	X	X	X	X
PIPS plan integrates the level of harm, levels of review, and classification language event • morbidity • mortality without opportunities for improvement, eventmorbidity • mortality with opportunity for • improvement, and event/morbidity • mortality with regional opportunity for improvement.	X	X	X	X
Trauma activation guidelines are followed.	X	X	X	X
A delayed trauma activation, wrong level of trauma activation, or a missed trauma activation occurred.	X	X	X	X
Physician response times for trauma activation levels are met.	X	X	X	X

Required Screening Events for Trauma PIPS	Level I	Level II	Level III	Level IV
All Levels				
Over and under triage are monitored and reported quarterly to the Trauma Operations Committee.	X	X	X	X
Delays in care due to the unavailability of emergency department (ED) physician (Level III, IV)			X	X
Lack of availability of essential equipment for resuscitation or monitoring occurred.	X	X	X	X
Resuscitation guidelines and resuscitation documentation meets established guidelines.	X	X	X	X
Initial and serial vital signs and GCS are documented, assessments and reassessments are monitored.	X	X	X	X
Massive transfusion protocol activations are monitored. MTPs that have incorrect products or ratios, a delay in arriving at the patient's bedside, or blood wastage are reviewed through the secondary and tertiary level of review.	X	X	X	X
Inadequate or delayed blood product availability.	X	X	X	X
Transfers out of the facility are reviewed for decision time to transfer, time-sensitive transfers, and facility delays contributing to delays in transfers as well as transport availability. Time-sensitive transfers are transferred in under 2 hours from time of arrival to time leaving the facility.	X	X	X	X
Trauma transfers out of the facility that are not time-sensitive transfers have a transfer time from arrival to departure within the facility defined time period.	X	X	X	X
Pediatric or geriatric resuscitation guidelines and documentation meet trauma management guidelines.	X	X	X	X
Pediatric radiology ALARA guidelines are followed.	X	X	X	X
Pediatric weight is recorded in Kg.	X	X	X	X
Pain management guidelines are followed.	X	X	X	X
Pediatric initial and serial vital signs and GCS are documented for patients with shock, potential TBI, or multisystem injuries.	X	X	X	X
Pediatric equipment is available for resuscitation in diagnostic areas, OR, and inpatient areas.	X	X	X	X

Required Screening Events for Trauma PIPS	Level I	Level II	Level III	Level IV
All Levels				
Missed recognition or treatment of shock, defined as a systolic BP of 110 or less, in the geriatric (65 or older) population occurred.	X	X	X	X
Delays in access to time-sensitive diagnostics or therapeutic interventions occurred.	X	X	X	X
When requested, radiologist responds and completes the review of images within 30 minutes.	X	X	X	X
Radiology interpretation errors or discrepancies preliminary and final reports occurred.	X	X	X	X
Orthopedic urgent response time and assessment standard is met.	X	X	X	X
Orthopedic management guidelines are followed.	X	X	X	X
Identified open fractures and the patient does not receive antibiotics within 60 minutes of prehospital contact or on arrival (private vehicle)	X	X	X	X
Neurosurgical urgent response time and assessment standard is met.	X	X	X	
Neurosurgical trauma management guidelines are followed.	X	X	X	X
DVT prophylaxis guidelines are followed.	X	X	X	X
Delayed recognition of an injury or a missed injury occurred.	X	X	X	X
Compliance with trauma policies related to timely access to the OR for urgent surgical intervention.	X	X	X	X
Unanticipated return to the OR occurred or an unplanned trip to the OR occurred.	X	X	X	X
Delays in response to ICU for patients with critical needs.	X	X	X	X
Unanticipated transfer to the ICU or intermediate care occurred.	X	X	X	X
All nonsurgical admissions (refer to ACS standard 7.8)	X	X	X	
Transfers from inpatient unit to another facility for definitive care are reviewed through the secondary and tertiary levels of review.	X	X	X	X
Registry data is submitted to the state trauma registry quarterly.	X	X	X	X
Documented evidence that registry data is validated and includes the patient's ISS score	X	X	X	X

Required Screening Events for Trauma PIPS	Level I	Level II	Level III	Level IV
All Levels				
Diversion time is monitored and reviewed to define the reason for diversion and identify trends. Corrective action plans are implemented, and data is presented at the Trauma Operations Committee.	X	X	X	X
Abuse screening for all ages is completed and documented, and when suspected or confirmed referrals are documented.	X	X	X	X
All identified opportunities for regional improvement are referred to the local regional trauma advisory council.	X	X	X	X
Complications and adverse events are identified and reviewed through the trauma PIPS process.	X	X	X	X
Transfers to hospice are included in the mortality reviews.	X	X	X	X
All deaths or mortalities (DOAs, DIED, inpatients deaths, patients made DNR after admission for injury, or decisions for comfort care after admission for injury) have a detailed, in-depth PIPS review through the secondary and tertiary level of review.	X	X	X	X
Referral for organ procurement is monitored.	X	X	X	X
Screening of eligible patients for psychological sequelae occurs.	X	X		
Timeliness of rehab services (OT, PT, Speech) response and availability are monitored and reviewed through the secondary and tertiary level of review.	X	X	X	X
Patients, 12 years of age or older, admitted for trauma injuries are screened for substance use, misuse, and if screening is positive, intervention or referral is provided.	X	X	X	X
Variances in following the trauma management guidelines or best practice guidelines are identified and processed through the PIPS process.	X	X	X	X
Variances in backup call schedule or contingency plan are monitored through the PIPS process.	X	X	X	X
Telemedicine utilization without video capabilities is reviewed through the secondary and tertiary level of review and includes the telemedicine providers.	X	X	X	X

Required Screening Events for Trauma PIPS	Level I	Level II	Level III	Level IV
All Levels				
Telemedicine without appropriate documentation is reviewed through the secondary and tertiary level of review.	X	X	X	X
Telemedicine failure to participate in PI process.	X	X	X	X
Failure to document and include the wristband number in the registry and EMR.	X	X	X	X
Peer review committee meeting attendance does not meet standards.	X	X	X	X
Physicians participating in the trauma call panel who are not board-certified and not compliant with ATLS, or have an approved physician requirement exception are quickly identified and reviewed by the TMD.	X	X	X	X
Required education and certification for designation are monitored for compliance.	X	X	X	X
EMS and transferring facilities are provided follow-up information or feedback regarding identified injuries, identified opportunities, or as follow-up is requested.	X	X	X	X
Facilities complete the Pediatric Readiness survey annually.	X	X	X	X
Gaps in pediatric readiness are addressed through the trauma operations committee and trauma PIPS process until resolved.	X	X	X	X
Adult trauma facilities complete a pediatric trauma simulation every six months and findings are integrated into the trauma PIPS process and tracked through the operations committee until resolved (**Note**: Adult trauma facilities that admit 200 or more pediatric trauma patients that have an ISS of 9 or greater are exempt from the simulation training or if the facility has an actual pediatric trauma resuscitation within the six-month timeframe.)	X	X	X	X
Pediatric psychosocial support services are available.	X	X		

APPENDIX C: TRAUMA REGISTRY AND DATA MANAGEMENT PROCESS

Trauma Registry and Data Management

National Trauma Data Standard (NTDS) Patient Inclusion Criteria

Description: To ensure consistent data collection across States into the National Trauma Data Standard, a trauma patient is defined as a patient sustaining a traumatic injury within 14 days of initial hospital encounter and meeting the following criteria*.

At least one of the following International Classification of Diseases, Tenth Revision (ICD-10- CM) injury diagnostic codes defined as follows:

- S00-S99 with 7th character modifiers of A, B, or C only (Injuries to specific body parts - initial encounter)
- T07 (unspecified multiple injuries)
- T14 (injury of unspecified body region)
- T79.A1-T79.A9 with 7th character modifier of A only (Traumatic Compartment Syndrome - initial encounter)

Excluding the following isolated injuries (ICD-10-CM):

- S00 (Superficial injuries of the head)
- S10 (Superficial injuries of the neck)
- S20 (Superficial injuries of the thorax)
- S30 (Superficial injuries of the abdomen, pelvis, lower back, and external genitals)
- S40 (Superficial injuries of shoulder and upper arm)
- S50 (Superficial injuries of elbow and forearm)
- S60 (Superficial injuries of wrist, hand, and fingers)
- S70 (Superficial injuries of hip and thigh)
- S80 (Superficial injuries of knee and lower leg)
- S90 (Superficial injuries of ankle, foot, and toes)

Late effect codes, which are represented using the same range of injury diagnosis codes but with the 7th digit modifier code of D through S, are also excluded and must include one of the following in addition to ICD-10-CM S00-S99, T07, T14, and T79.A1-T79.A9:

- Death resulting from the traumatic injury (independent of hospital admission or hospital transfer status); or
- Patient transfer from one acute care hospital** to another acute care hospital; or
- Patients directly admitted to your hospital (exclude patients with isolated injuries admitted for elective and/or planned surgical intervention); or
- Patients who were in-patient admission and/or observed

*In-house traumatic injuries sustained after initial ED/Hospital arrival and before hospital discharge

at the index hospital (the hospital reporting data), and all data associated with that injury event, are excluded.

**Acute Care Hospital is defined as a hospital that provides inpatient medical care and other related services for surgery, acute medical conditions, or injuries (usually for a short-term illness or condition).

"CMS Data Navigator Glossary of Terms" - https://www.cms.gov/Research-Statistics-Data- and systems/Research/ResearchGenInfo/Downloads/DataNav_Glossary_Alpha.pdf (accessed January 15, 2019). Copyright 2021 American College of Surgeons, Committee on Trauma

ACS Website
National Trauma Data Standard (NTDS) | ACS (facs.org)

TQIP Website
Trauma Quality Improvement Program (TQIP) | ACS (facs.org)

Texas Department of State Health Services EMS and Trauma Registries Website
EMS and Trauma Registries | Texas DSHS

APPENDIX D: OUTREACH EDUCATION, PREVENTION, PUBLICATIONS, RESEARCH

Trauma Program Outreach Education, Prevention, Publications, and Research Tracking

American College of Surgeons (ACS) Requirements for Level I, II, and III Trauma Facilities

Outreach Education

8.1 Public and Professional Trauma Education
All trauma centers must provide public and professional trauma education.

Prevention

2.13 Injury Prevention Program
All trauma centers must have an injury prevention program that:

1. Has a designated injury prevention professional
2. Prioritizes injury prevention work based on trends identified in the trauma registry and local epidemiological data
3. Implements at least 2 activities over the course of the verification cycle with specific objectives and deliverables that address separate major causes of injury in the community
4. Demonstrates evidence of partnerships with community organizations to support their injury prevention efforts

Research

9.1 Research and Scholarly Activities
Level I trauma centers must demonstrate the following scholarly activities during the verification cycle:

1. At least 10 trauma-related research articles*
2. Participation by at least 1 trauma program faculty member as a visiting professor, invited lecturer, or speaker at a regional, national, or international trauma conference.
3. Support of residents or fellows in any of the following scholarly activities: laboratory experiences; clinical trials; resident trauma paper competitions at the state; regional, or national level; and other resident trauma research presentations.

(ACS Resources for Optimal Care of the Injured Patient, 2022 Standards, Released March 2022)
(Updated July 2025)

Awareness Education Prevention Research

Please complete the table below. Copy a link for associated handouts or documents in the "Program" area or scan and attach the documents in the order listed.

Public Awareness Programs Provided				
Program	**Date**	**Targeted Audience**	**Facility Lead**	**Outcome**

Please complete the table below. Copy a link for associated handouts or documents in the "Program" area or scan and attach the documents in the order listed.

Outreach Education Programs Provided				
Program	**Date**	**Targeted Audience**	**Number of Participants**	**Outcome**

Please complete the table below. Copy a link for associated handouts or documents in the "Program" area or scan and attach the documents in the order listed.

Prevention Programs Provided				
Program	**Date**	**Targeted Audience**	**Goal of Program**	**Outcome**

Please complete the table below and provide references for any research by the facility utilized in abstracts, podium presentations, or publications.

Research Activities				
Research Project	**Principle Investigator**	**Funding/ Sponsor**	**Goal of Research**	**Outcome/ References**

APPENDIX E. REQUIRED DOCUMENTS, MEDICAL RECORD REVIEW PLANNING AND MEDICAL RECORD FACE SHEET

Trauma Medical Record Face Sheet

Link to electronic document (to be completed on every chart selected).

<table>
<tr><td rowspan="2">Patient Injury Diagnosis</td><td colspan="3">Last Name:</td></tr>
<tr><td>Age/Gender</td><td colspan="2">Mechanism of Injury</td></tr>
<tr><td>MRN/Trauma Registry #</td><td colspan="3"></td></tr>
<tr><td>Injury Category</td><td colspan="3"></td></tr>
<tr><td>ISS</td><td colspan="3"></td></tr>
<tr><td>EMS Scene Time / Summary
Prehospital Whole Blood or Blood Component Administered</td><td colspan="3"></td></tr>
<tr><td>Trauma Team Activation</td><td colspan="3">Yes ☐ No ☐ Level: _____
Timely Activation ☐ Delayed Activation ☐
Missed Activation ☐ Wrong Level
of Activation ☐</td></tr>
<tr><td>Patient Arrival at Trauma Resuscitation Bay/ED</td><td>Date:</td><td>Time:</td><td>Surgeon/Physician Arrival Time:</td></tr>
<tr><td>Time of Initial Imaging</td><td>Chest Xray</td><td>Pelvic Xray</td><td>CT:

CTs obtained:</td></tr>
<tr><td>MTP Activated</td><td colspan="3">Yes ☐ No ☐ If yes, time requested:
_____ Time of first unit:_____</td></tr>
<tr><td>Consultant Services engaged in resuscitation/ evaluation</td><td colspan="3"></td></tr>
</table>

Response time for services meeting the 30-minute response requirement	Neuro	Ortho	IR
Patient ED Disposition	OR ☐ Floor ☐ ICU ☐ IR ☐ Transfer ☐ If transferred, transfer decision time: Total transfer time:		Other
OR Timeline (if ED Disposition) OR Procedures:	In OR	Incision	Out of OR
Disposition after OR	Floor ☐ ICU ☐ Expired in OR ☐		Other
	Date/Time:		
Length of Stay:_____	ED: Expired in Resuscitation	ICU: Vent Days: Expired in ICU ☐	Hospital: Expired in Hospital ☐
SBIRT Screening Completed	Yes ☐ No ☐ NA ☐		
If Yes, SBIRT Intervention Offered	Yes ☐ No ☐		
Timeline of transfers between units (up to 3 after final destination noted above)	Date	Time	
	Date	Time	
	Date	Time	
1. PI Event Identified and Level of Harm Event: _____ Level of Harm: _____ Date: _____	Primary Review: Yes ☐ No ☐ Date: _____ Secondary Review: Yes ☐ No ☐ Date: _____ Tertiary Review: Yes ☐ No ☐ Date: _____		

Action Items that Occurred as Result of Review:	Event Resolution: Yes ☐ No ☐ Ongoing ☐

2. PI Event Identified and Level of Harm Event: _____ Level of Harm: Date: _____	Primary Review: Yes ☐ No ☐ Date: _____ Secondary Review: Yes ☐ No ☐ Date: _____ Tertiary Review: Yes ☐ No ☐ Date: _____
Action Items that Occurred as Result of Review:	Event Resolution: Yes ☐ No ☐ Ongoing ☐
3. PI Event Identified and Level of Harm Event: _____ Level of Harm: _____ Date: _____	Primary Review: Yes ☐ No ☐ Date: _____ Secondary Review: Yes ☐ No ☐ Date: _____ Tertiary Review: Yes ☐ No ☐ Date: _____
Action Items that Occurred as Result of Review:	Event Resolution: Yes ☐ No ☐ Ongoing ☐
Outreach Education to Transferring Facility/Transport:	Identified and Documented: Yes ☐ No ☐

Trauma Medical Record Review Planning

The facility trauma program defines the reporting period for the survey as the DAQ is completed. The medical records selected for the review are identified by categories and selected in reverse chronological order. The number of medical records to prepare per category is defined by the level of designation and number of surveyors. The program will complete a Medical Record Face Sheet for each trauma medical record as requested.

Program will copy and add the admission H&P and the discharge summary for inclusion in the shared file. Medical records outside of the reporting period may be included during this process to ensure appropriate review of trauma care. These documents are prepared and placed in the shared file 45 days prior to the survey.

The Trauma Medical Director, Trauma Program Manager, performance improvement staff, registry staff, and administrator will meet with the surveyors 20 days prior to the survey and finalize the medical record selection for review. The facility decides if the medical records will be reviewed in the EMR or if physical copies of the medical records selected are placed in the shared file. If the facility agrees to copy the medical records, this must be completed and placed in the shared file

no later than 5 days before the survey.

The program prepares associated trauma PIPS documents specific to the selected medical records. Documentation includes:

1. Associated minutes of the trauma operations and multidisciplinary peer review committees
2. Defined opportunities for improvement
3. Corrective actions
4. Data reflecting the corrective action plan monitoring
5. Trauma management guidelines specific to the medical record
6. Trauma registry profile

The completed file must be added to the shared file no later than 5 days prior to the survey for all virtual surveys. If the survey is onsite, the files will be prepared and organized for the medical record review.

The medical record selections are defined by medical record review categories for initial, renewal, or focused/full surveys as specified by the department.

Each surveyor is required to review 10 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 medical records for adults and 45 medical records for pediatrics)
- 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

The program staff prepares the medical records selected by the surveyors and any additional records requested. There may be instances where medical records fall into multiple categories. Place the medical record in the category deemed most appropriate. Please do not duplicate charts in more than one category. For example, if the case resulted in mortality, the best category would be death.

Not all categories will have the required number of records available during the reporting period. In this instance, pull the medical records that are available. If it is necessary, medical records from

the designation cycle may be included in the survey.

For facilities with contingent designations, requiring a focused survey, the medical records and PIPS documentation must be selected for the identified requirements not met during the initial survey, and medical records cannot be from prior to the initial survey date. The department may define specific requirements for the focused survey.

For facilities with contingent probationary designations requiring survey, the medical records prior to the initial survey cannot be utilized for this survey.

Each medical record selected must have a Trauma Medical Record Face Sheet completed by the facility. The medical records and attached documents noted below must represent trauma activities consistent with the reporting period used to complete the online DSHS Designation Assessment Questionnaire (DAQ).

If the facility agrees to a virtual survey, there must be an agreement between the facility and the surveyors regarding the process for the medical record review. It is strongly recommended to complete the medical record review utilizing the EMR even in the virtual surveys. The program makes this decision, not the survey organization. This prevents the unnecessary burden of the program printing out medical record documents.

If a virtual EMR review is not the program's choice, the program prepares the documents for review. The medical records and attached documents must be:

1. Converted into a portable document format (PDF).
2. Bookmarked through Adobe Acrobat Pro® or other premium product – full-featured PDF creator/editor.
3. Labeled/indexed based on the categories noted below in the "administrative" section.
4. Shared via an electronic HIPAA-compliant transfer or shared file system (Ex: secured email, DropBox, SharePoint, ShareFile, or any system approved by the facility's Chief of IT, Chief of Quality, and CNO.
5. Provided to the survey team as early as the facility schedule allows but no later than 5 days prior to the survey visit. We encourage trauma facilities to provide medical records and PIPS documentation prior to the pre-survey conference call to ensure the files are accessible.

Medical Record Review Documentation Requirements

The required documentation listed below must be bookmarked and labeled/indexed to each medical record selected by the lead surveyor in the following chronological order:

1. Trauma Medical Record Face Sheet
2. PIPS documentation to include:
    a. Event identification and date
    b. Level of harm
    c. Primary level of review
    d. Secondary level of review
    e. Tertiary level of review
    f. Minutes of case discussions to include data and attendance
    g. Opportunities for improvement

h. Corrective actions
i. Data to measure the impact of the corrective actions through to event resolution
j. Documentation of each level of review, including the date(s) and all supporting information, with the case highlighted, if multiple cases are present
k. Must include documentation of complete event resolution

3. Prehospital and transport patient care records to include blood administration records if applicable.
4. Transfer information from the initial hospital (if applicable)
5. Transfer to trauma facility documentation
6. Trauma flow sheet (or ED documentation if not a Trauma Team Activation (TTA))
7. Mass Transfusion Protocol (MTP) summary (count of products including cryoprecipitate)
8. ED physician note
9. Trauma History & Physical (H&P)
10. Consultation notes (for specialist(s) consulted in first 12 hours from arrival in the ED)
11. Operative notes within anesthesia sheet (for procedures in first 48 hours)
12. Imaging reports (for studies within first 12 hours)
13. SBIRT Screening – Screening, Brief Intervention, and Referral to Treatment
14. Abuse screening - Child protective services consult (peds only)
15. Discharge summary
16. Autopsy report, if applicable
17. Copy of the management guidelines/protocols followed to care for the injured trauma patient, e.g., MTP activation, trauma team activation, specialty consult services, neurosurgery/ orthopedic surgery (if applicable), organ procurement, etc.

Physician progress notes and diagnostic imaging are not required to be scanned and sent in advance. They may be requested during the survey visit upon the surveyor's request.

Medical Record Review Categories: Priority is Trauma Patients Who Meet Trauma Activation Requirements	**Patients Admitted for Trauma Care to the Facility**		
Level I, II, III, and IV *	**Adults Only**	**Adults and Children**	**Children Only**
Neurosurgical Injuries (Total of 12 charts with a minimum of 2 charts from each of the subcategories)			
• Epidural/subdural hematoma taken to the OR	X	X	X
• Severe TBI (GCS less than or equal to 8) admitted to an ICU, excluding the mechanism of Physical Child Abuse	X	X	X
• Spinal cord injury with neurologic deficit	X	X	X
Orthopedic Injuries (Total of 15 charts with a minimum of 2 charts from each of the subcategories)			

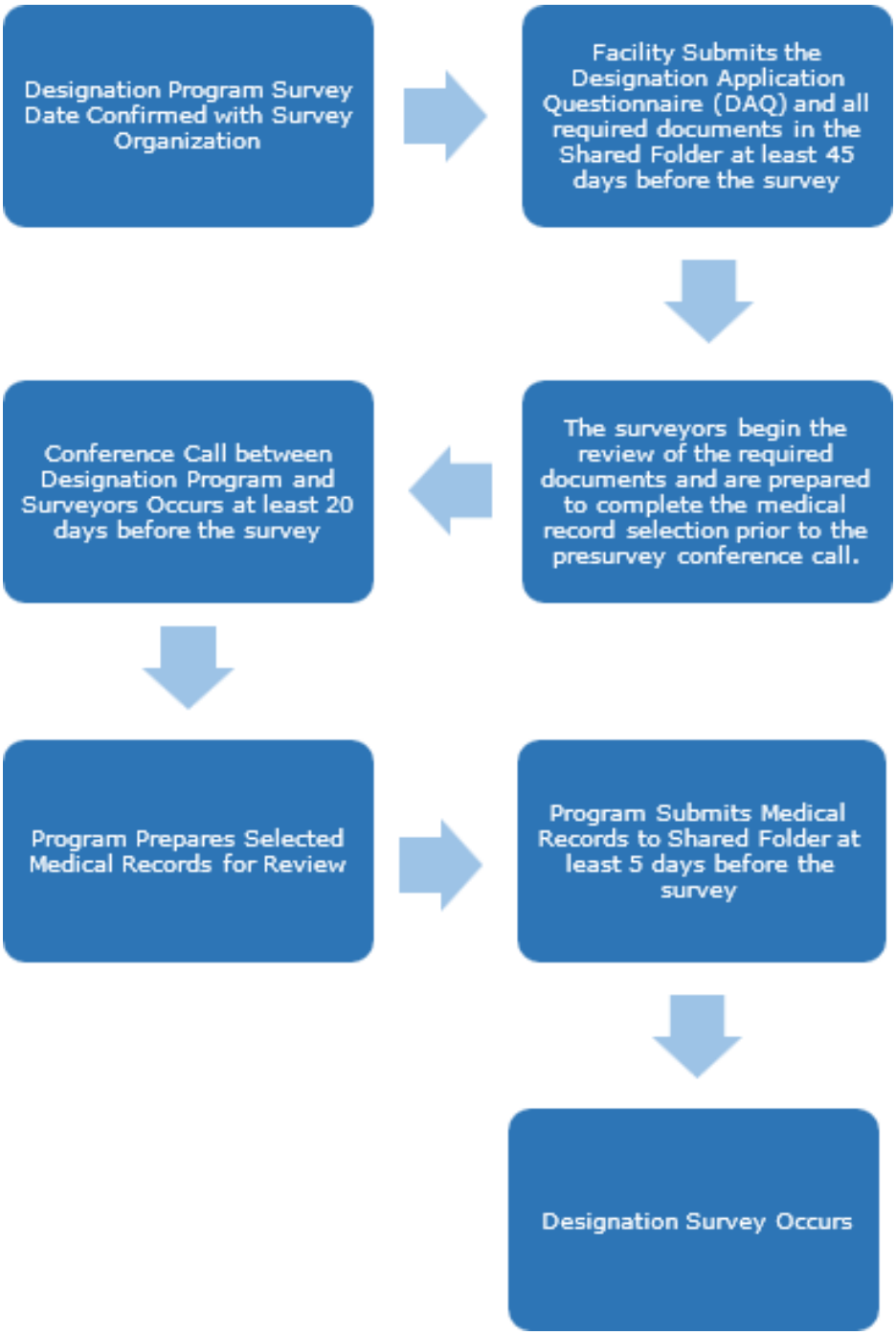
• Supracondylar elbow fractures with neuro-vascular compromise		X	X
• Any amputations excluding digits	X	X	X
• Acetabular fractures and any pelvic fractures requiring embolization, transfusion, or surgery/ORIF	X	X	X
• Open femur or tibia fractures	X	X	X
Abdominal and Thoracic Injuries (Total of 15 charts with a minimum of 2 charts from each of the subcategories)			
• Thoracic/cardiac injuries (include aortic), AIS greater than or equal to 3 or requiring intervention (intubation, surgery, IR)	X	X	X
• Solid organ injuries; spleen, liver, kidney, and pancreas: greater than or equal to Grade III or requiring intervention (transfusion, embolization, surgery)	X	X	X
• Penetrating neck, torso, proximal extremity trauma, with ISS greater than or equal to 9, or requiring intervention (transfusion, chest tube, IR, surgery)	X	X	X
• Trauma activations, ED to OR admissions for trauma, orthopedics, or neurosurgery	X	X	X
• Trauma activations, ED to ICU admissions for trauma, orthopedics, or neurosurgery	X	X	X
• Trauma activations with abdominal or thoracic injuries requiring blood transfusion	X	X	X
• ISS of 15 or higher.	X	X	X
Non-Surgical Admissions and Transfers (Total of 10 charts with a minimum of 2 charts from each of the subcategories)			
• Physical child abuse (suspected and/or confirmed) with an ISS greater than or equal to 9		X	X
• Patients admitted to non-surgical services with an ISS greater than or equal to 9	X	X	X
• Patients admitted to non-surgical services with an ISS greater than or equal to 9 for geriatric hip fractures	X	X	
• Transfer out for the management of acute injury	X	X	X
Adverse Events (Total of 5 charts)			
• Any major complication or unexpected return to the SICU/PICU or the OR	X	X	X
• ISS greater than 25 with survival, without severe TBI (Head AIS less than 3)	X	X	X
Massive Transfusion Protocol (MTP) (Total of 5 charts)			
• This will include: MTP Activation criteria, timing of hemorrhage control, prehospital interventions, and timing, resources in the ED, time in the ED with hypotension prior to hemorrhage control, outcomes, and timing of consults	X	X	X

Prehospital Whole Blood Administration (3 records)	X	X	X
Highest Level or second level of trauma activation transfers out of the ED (5 records)	X	X	X
Patients who met trauma team activation criteria that are transferred from the inpatient setting (4 records)	X	X	X
OB trauma patient who met trauma team activation criteria and is greater than 20 weeks pregnant with ISS score 9 or greater (3 records)	X	X	X
Hospice (Total of 2 charts)			
• Care provided up to the time of transfer will be evaluated	X	X	
Deaths (Total of 20 charts with a minimum of 5 charts from each of the subcategories)			
• Mortality without opportunity for improvement	X	X	X
• Mortality with opportunity for improvement	X	X	X
• Mortality with regional opportunity	X	X	X
• Unable to determine	X	X	X

The trauma center is encouraged to identify two great saves or exemplary resuscitations for the medial record review or two cases that demonstrate excellence in system response.

* Level IV facilities managing 100 or less will choose medical records from these categories based on their volume and services provided meeting trauma activation guidelines.

Medical Record Planning Submission Timeline



Designation Survey Team Composition

Designation Program Surveyors	Level I	Level II	Level III	Level IV
Trauma Designation				
Level IV Managing 100 or less				
One surveyor				X
Trauma surgeon, emergency medicine physician, or family practice physician, currently in the role of TMD or trauma liaison, or RN with trauma expertise.				X
Level IV Managing 101 or more				
Evidence of operative intervention, ICU admission, or ISS of 15 or greater – 2 surveyors				
Trauma Surgeon (1)				X
RN with Trauma Expertise (1)				X
Evidence of ICU admission or ISS of 15 admission – 2 surveyors				
Trauma Surgeon, emergency medicine physician, or family practice physician, who currently have the role of TMD or trauma liaison (1)				
RN with trauma expertise (1)				X
No evidence of operative intervention or ICU admission or ISS of 15 or greater - 1 surveyor				
One surveyor: Trauma Surgeon, emergency medicine physician, or family practice physician, who currently have the role of TMD or trauma liaison, or RN with trauma expertise				X
Level III				
Trauma Registered Nurse (1)			X	
Trauma Surgeon (1)			X	
Level II				
Trauma Registered Nurse (1)		X		
Trauma Surgeon (2)		X		
Emergency Medicine Physician (1)		X		
Level I				
Trauma Registered Nurse (1)	X			
Trauma Surgeon (2)	X			
Emergency Medicine Physician (1)	X			

APPENDIX F: CONFLICT OF INTEREST DOCUMENT

Surveyor Conflict of Interest Assessment
Go to the next page to view the form.

Surveyor Conflict of Interest Assessment

On 8/31/2025 , you agreed to participate in the type of survey designation survey for Name of facility .
Facility address

In the last four years:

I ○ **have** ○ **have not** trained or supervised key hospital or medical staff in residency or fellowship.

I ○ **have** ○ **have not** collaborated professionally with key members of the facility's leadership team.

I ○ **have** ○ **have not** been employed in the same health care system in state or out of state.

I ○ **have** ○ **have not** participated in a designation consultation or designation survey with the facility.

I ○ **have** ○ **have not** had a previous working relationship with the facility or a facility leader.

I ○ **am** ○ **am not** an EMS medical director for an agency that routinely transports trauma patients to the facility.

I ○ **do** ○ **do not** live or practice in the same regional advisory council or a contiguous regional advisory council.

I confirm the above information is accurate.

Signature _____ Date _____

(The survey organization has the option of creating a similar conflict of interest form with these statements and define how this form will be retained, in the event questions occur.)

APPENDIX G: SURVEY ORGANIZATION APPLICATION

Texas DSHS Designation Survey Organization Application
Go to the next page to view the application.

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

Texas DSHS Designation Survey Organization Application

Submission of a completed application by a survey organization is for approval to conduct surveys to evaluate that an eligible facility has met the Texas Administrative Code requirements for designation.

The initial application to be recognized as a department-approved survey organization will be opened September 1, 2025. The application must be submitted to the department prior to November 1, 2025 at 11:59 pm.

Department-approved survey organizations must complete a new application every four years prior to expiration using the same process.

The period for renewal application submission will be between January 1 and January 31 of every year.

Complete an application for each designation program requested.

Submit: Email the completed application and required documentation as an attachment to: DSHS.EMS-TRAUMA@dshs.texas.gov

Subject line: "Survey Organization Application - Organization Name or Acronym"

Note: Our email system does not currently accept large email attachments. You may need to submit your documentation in multiple emails.

Please contact a designation staff member for questions.

Designation Survey Organization Information

Designation Survey Organization

Legal Name _____

Legal Address _____

Address 2 _____

City _____

State TX _____

Zip Code _____

Contact Name & Title _____

Email Address _____

Phone Number _____

Government Liaison/Survey Director Contact

Name & Title _____

Address _____

Address 2 _____

City _____

State TX _____

Zip Code _____

Email Address _____

Phone Number _____

Texas DSHS Designation Survey Organization Application

Designation Program and Level(s) Requested to Survey

Level I ☐ Level II ☐ Level III ☐ Level IV ☐ Designation Program: Select one

Does the organization provide consultation surveys? Yes ◯ No ◯

Please provide the following information as attachments:

1. Describe the history and qualifications of the organization's oversight of the survey process for the type and levels of designation surveys requested for approval.
2. How many regular surveys were performed by the organization in the previous full calendar year by type and level?
3. How many focused surveys were performed by the organization in the previous full calendar year by type and level?
4. Define the capabilities to conduct surveys on-site, virtually and as a hybrid.
5. How many surveys were completed in-person, virtually, or as a hybrid by the organization in the previous full calendar year by type and level?
6. Define the selection process to identify qualified individuals to serve as surveyors.
7. Define the process for validating all surveyors meet the defined surveyor requirements.
8. Provide an overview and schedule of the organization's surveyor training which must include:
    a. An overview of the specific rules for designation and additional requirements referenced in the rules (ACS, BAC, etc.);
    b. How to document evidence that designation requirements are met in the survey summary report and the medical record reviews;
    c. How to conduct a survey as the lead surveyor or a survey team member;
    d. Successful completion of conducting a survey with a senior surveyor evaluator prior to independent surveying; and
    e. Attendance at a DSHS Designation Surveyor Training.
9. Define the process for validating each surveyor has completed a trauma performance improvement course approved by the department in the past four years.
10. Define how current designation requirements are integrated into the surveyor training and the plan to integrate any adopted rule requirements.
11. Define the process to provide updates to all surveyors.
12. Define the process for ensuring surveyors do not have a conflict of interest with the facility they are scheduled to survey.
13. Define the process for ensuring each surveyor completes a minimum of two surveys annually.
14. Define the organization's oversight and performance improvement process for each surveyor including:

a. Performance before, during, and after a survey;
b. Demonstrates effective time management skills to ensure the survey begins and ends on time;
c. Completion of ten medical record reviews to include review of the associated performance improvement measures;
d. Quality of the documentation in the survey summary reports and medical record reviews;
e. Completion of the assignments specific to the designation survey guidelines
f. Failure to address or assess a designation requirement;
g. Documentation in the survey summary report and medical record reviews is objective and supported with data; and
h. Ensuring the department recommendations for opportunities to improve surveyor performance is shared with the surveyor.

15. Define the organization's plan to address non-professional behavior or other issues with a surveyor.
16. Provide the survey summary form and documented requirements or standards that the survey organization uses to evaluate each type and level of designation.
17. Provide the process for medical record selection.
18. Provide the medical record review tool and requirements for documentation of care provided to the patient population.
19. Define the process to ensure the confidentiality of all information as required by rule and law.

APPENDIX H: FACILITY WALK-THROUGH REVIEW GUIDELINES

Survey Walk-Through Assessment and Overview

Purpose

Assess the facility design, organization, and flow of care for the trauma patient. Assess staff's knowledge, training, and level of readiness to care for the trauma patient. Complete necessary interviews in the various departments providing care to the trauma patient.

The lead surveyor may divide surveyors into specific areas to make this process more time efficient. Determine ahead of time which departments will be visited and the required staff to be available to speak to the surveyors. The facility may choose to have additional staff present in areas during the tour.

Direct questions to the staff and not to the Trauma Medical Director (TMD), Trauma Program Manager (TPM), or leadership. Surveyors may adapt the questions to the level of care provided. Surveyors may be asking questions to different staff members simultaneously.

Scenarios may be used at any point during the tour to elicit answers to the questions. A group discussion may be conducted to obtain required information from trauma care team members who are unavailable during the tour.

A surveyor may choose to activate the trauma team to evaluate the facility's response.

Resuscitation Area/Emergency Department (ED)

Purpose
To review the ED's capabilities and capacity to care for the mild to critically ill or complex trauma patient; the physical layout, services, and resources available for the trauma patient 24 hours per day; and the trauma management guidelines for the Emergency Medical Services (EMS) and ED.

Surveyors
Physician(s) and Registered Nurse

Facility Staff Present
TMD
TPM
ED Director/Manager
Trauma Emergency Medicine Liaison
Administrator
EMS Representative/Local EMS Medical Director
ED Registered Nurses (RN)
Radiology Technician
Radiologist
Respiratory Therapist
Blood Bank
Spiritual Care
Security
Facility Emergency Management Leader
Transfer Center Staff

Surveyors are encouraged to engage any patient care staff or ancillary care staff present on the unit during the tour. The surveyors may also interview parents, guardians, or family members if they are agreeable.

Questions/Assessment

EMS Representative

1. Describe EMS communication processes.
2. Define access to prehospital whole blood and the rotation process.
3. Can EMS activate the trauma team from the field?
4. Discuss the facility's history of diversion and the impact on patient destination and any significant hall-wait times.

ED Clinical Staff/Leadership

1. Assess the EMS Dock and Helipad
2. What is the process of receiving/transferring a trauma patient by helicopter?
3. How does a mass casualty change the flow in the EMS receiving area?
4. How is disaster triage setup, and where is that located?
5. How is medical decontamination organized?
6. Where are the decontamination suits located?
7. On any given shift, how many people have disaster and/or decontamination training?
8. Identify barriers to receiving trauma patients.
9. What plans are in place to address the barriers?
10. How is EMS timeout performed, and how is it documented?
11. How is the EMS wristband number documented, tracked, and is it a searchable field in the electronic medical record?
12. How does the facility provide feedback to the EMS personnel regarding a patient transported to the facility?
13. Describe how the trauma team is activated.
14. Who can activate the trauma team?
15. Who are the members of the trauma team?
16. Define the staffing pattern for the highest level of activation.
17. What is the role of non-clinical trauma team members, if applicable?
18. How are ED clinical and ancillary staff educated and trained on the activation criteria, the activation process, and their roles and responsibilities?
19. How are the activation response times recorded and monitored?
20. Define how staff are educated and trained regarding their role in the trauma care management guidelines and documentation requirements.

21. How are ED staff educated and trained to manage trauma patients?
22. What competencies and certifications are required for the ED staff?
23. Is there a designated area or room for the treatment of the trauma patient?
24. Who oversees the trauma resuscitation?
25. Who is responsible for the patient's airway management?
26. What were your Pediatric Readiness scores during the designation cycle?
27. How do you monitor staff's readiness to care for a seriously injured child?
28. How do you ensure the pediatric equipment is readily available for all sizes of pediatric patients?
29. What guidelines are in place for the geriatric trauma patient?
30. How is shock defined in the geriatric patient?
31. How is your facility prepared to manage a significantly injured 26-week pregnant patient?
32. Who responds to an OB/trauma patient trauma activation?

Respiratory Therapy (RT)

1. Describe the role in intubation and vent management.
2. Is end-tidal CO2 monitoring available in the resuscitation room?
3. Are there protocols that define the criteria for utilizing end-tidal CO2 monitoring?
4. If not, how is airway patency monitored?

ED Clinical Staff/Leadership

1. What is your role in the prehospital whole blood initiative?
2. Is the Focused Assessment with Sonography in Trauma (FAST) exam utilized?
3. If yes, who is credentialled to complete a FAST exam?
4. How is this monitored through the trauma performance improvement and patient safety (PIPS) process?
5. How are identified opportunities addressed?
6. Where are the care management guidelines located?
7. Are pediatric care management guidelines available?
8. Describe how pediatric trauma resuscitations are managed (if not a pediatric facility).
9. Did the facility complete a pediatric readiness survey this year?
10. If yes, what opportunities for improvement were identified?
11. How are the opportunities being addressed and status?
12. Are care management guidelines for geriatric trauma available?
13. If yes, how are staff educated and trained on these guidelines?

14. How are these guidelines (pediatric and geriatric) incorporated into the trauma PIPS process?
15. What happens if a patient with an obvious pelvic fracture that is hypotensive is brought to the resuscitation room?

Laboratory

1. Are Point-of-Care tests available in the resuscitation rooms?
2. If yes, which tests are available, and what are their turn-around times? (TEG, ROTEM, ABGs, HH, etc.)
3. How are these times recorded and monitored?

Radiology

1. What are the expected turnaround times for chest and pelvic films?
2. If radiology is on-call, what is the expected call-back time, and how is this monitored?
3. Is there an expected turnaround time for Computed Tomography (CT)?
4. IF CT is on call, what is the expected call-back time, and how is this monitored?

Blood Bank

1. Are you a prehospital whole blood rotation site?
2. Do blood bank personnel respond to trauma team activation?
3. If so, how is this monitored?
4. If not, what is their expected response time after STAT request for Massive Transfusion Protocol (MTP), and how is this monitored?
5. Is whole blood available?
6. What is the MTP transfusion ratio?
7. Who monitors blood wastage?

ED Clinical Staff/Leadership

1. How did you prepare to become a prehospital whole blood rotation site?
2. Who is responsible for the EMS Time-Out documentation?
3. Where is the EMS wristband number recorded for tracking?
4. Who is responsible for documenting the injuries and completing the trauma History and Physical exam?
5. What barriers have been identified in expediting the admission/transfer of the trauma patient from the ED?
6. What plans are in place to address these barriers?
7. Do APPS assist with trauma resuscitations or patients meeting trauma activation criteria?
8. Describe how family care is provided.
9. How often are disaster drills held?

10. Describe the last disaster drill.
11. What was the scenario?
12. What lessons were learned?
13. Is training on roles and responsibilities during a disaster provided?

Transfer Center Staff

1. Describe how trauma transfers are initiated or accepted.
2. Describe how time-sensitive trauma transfers are expedited?
3. Do you have defined criteria for emergency and urgent transfers?
4. If yes, how is this monitored.
5. When was this procedure last revised? Was trauma, orthopedics, neurosurgery included in the revisions?
6. Does the transfer center oversee the diversion process?
7. What is the process of providing feedback to the transferring facility?
8. How does the facility provide feedback to the EMS personnel regarding a patient transported to the facility?
9. How are images shared between transferring and receiving facilities?
10. What barriers have been identified in expediting the admission/transfer of the trauma patient from the ED?
11. What plans are in place to address these barriers?

Psychosocial Services

1. Are chaplain services available?
2. Are social services available?
3. Are trauma counselors available?
4. Have staff been trained regarding trauma-informed care?
5. If yes, describe the consultation process for psychosocial services.
6. Is this documented in the electronic medical record (EMR)?

Security

1. Is security available?
2. If yes, what is their role and responsibilities?
3. Does the ED provide data to the Trauma Operations Committee?
4. How does the ED participate in the PIPS process and the Trauma Operations Committee?
5. Are there currently any performance improvement initiatives being worked on in collaboration with trauma services?

Telemedicine

Purpose
Review the process of providing or utilizing telemedicine, if applicable.

Surveyors
Physician and/or Registered Nurse

Facility Staff Present
TMD
TPM
ED Director/Manager
Trauma Emergency Medicine Liaison
Administrator
ED Registered Nurses
Telemedicine Staff (if provided by the facility or if utilized by the facility)

Questions/Assessment

Facilities Providing Telemedicine

1. Describe the process of receiving consults and providing recommendations.
2. Is there a contract for providing telemedicine services?
3. Does this contract define the expectations for:
    a. Participation in the performance improvement reviews and committee, and
    b. Participation, documentation, and credentialing of providers?
4. How is telemedicine incorporated into the trauma PIPS process?

Facilities Utilizing Telemedicine

1. Describe the process of requesting consults and receiving recommendations.
2. Is there a contract for utilizing telemedicine services?
3. Does this contract define the expectations for:
    a. Participation in the performance improvement reviews and committee, and
    b. Participation, documentation, and credentialing of providers?
4. How is telemedicine incorporated into the trauma PIPS process?

Radiology

Purpose
To review the physical layout, services, and resources available for the trauma patient 24 hours per day. Define how call-back times are monitored and reported.
Review the turn-around times for radiology reads.

Surveyors
Physician(s) and/or Registered Nurse

Facility Staff Present
TMD
TPM
Radiologist
Radiology Director/Manager
Radiology Technicians and/or Technician/RNs

Questions/Assessment

1. Define the timely access to imaging for the various levels of trauma activations.
2. Describe how call-back times are monitored and reported.
3. What are the turn-around times for radiologist imaging interpretations, and how is this monitored?
4. What is the response time of radiologist when requested to review specific images for critical trauma patients?
5. Is this data presented to the Trauma Operations Committee?
6. Is radiology notified when the trauma team is activated?
7. If so, how?
8. Does a staff member respond?
9. What are the expected response times, and how is this monitored?
10. If a radiology overread identifies deviation from the original read, how is this managed and monitored?
11. Is this data presented to the Trauma Operations Committee?

CT/CTA

1. Evaluate CT/CTA capabilities and capacity.
2. Describe the transport process of a trauma patient to CT/CTA scan.
3. Who monitors the patient while in CT/CTA scan?
4. Is there equipment for emergent resuscitation?
5. What is the process for prioritizing imaging when multiple patients are in line for CT/CTA scan?
6. What are the expected turnaround times of CT/CTA imaging?
7. Who does the initial reading of the CT/CTA images?
8. If radiology/CT staff is on-call, what are the expected response times, and how is this monitored?
9. Is this data presented to the Trauma Operations Committee?

Interventional Radiology (IR)

1. Evaluate IR capabilities and capacity.
2. What is the process for requesting a STAT IR procedure?

3. How are the response times for IR monitored and reported?
4. Describe the transport process of a trauma patient to IR.
5. Who monitors the patient while in IR?
6. Is there equipment for emergent resuscitation?
7. If IR staff is on-call, what is the expected response time, and how is this monitored?
8. Is this data presented to the Trauma Operations Committee?
9. What data does Radiology provide to the trauma PIPS?
10. How does Radiology participate in the PIPS process and the Trauma Operations Committee?
11. Are there currently any performance improvement initiatives being worked on in collaboration with trauma services?

Blood Bank

Purpose
To review the number of blood units and products available and the processes to have blood available for trauma emergencies. Review the MTP ratio and processes for moving the units to the trauma patient. Determine how blood shortages are addressed by the facility.

Surveyor
Physician(s) and/or Registered Nurse

Facility Staff Present
Blood Bank Director/Manager
Pathologist
TMD
TPM

Questions/Assessment

1. What is the Blood Bank's role in the prehospital whole blood initiative?
2. What is the procedure to secure uncrossed-matched O-negative blood for critical trauma patients in the resuscitation area?
3. Would whole blood be used instead of packed red blood cells?
4. Do you have a protocol for whole blood usage that defines which patients should receive whole blood?
5. What is the turnaround time for uncrossed-matched blood for the ED, OR, and ICU?
6. What is your relationship with the blood centers in the event you need blood products?
7. Who developed the MTP?
8. Who can initiate an MTP?
9. Do you have a policy with clearly defined criteria for initiating an MTP?
10. What are the processes for updating the protocol?
11. How is education provided to all areas regarding protocol updates?

12. How do the surgeon, pathologist, and anesthesia providers coordinate the needs of the bleeding trauma patient in the OR? Is there a written guideline?
13. How does this process change in a mass casualty event?
14. How are blood products managed in a mass casualty event??
15. How many simultaneous MTPs can your staff manage during a mass casualty event?
16. What data does the Blood Bank provide to the PIPS process?
17. How does the Blood Bank participate in the trauma PIPS process and Trauma Operations Committee?
18. Are there currently any performance improvement initiatives being worked on in collaboration with trauma services?

Respiratory Therapy

Respiratory Therapy questions are directed to the therapist in the resuscitation and ICU areas.

Operating Suite

Purpose
To review the operative suite hours of availability, staffing models, and access to a STAT room for critical trauma patients; the process for managing the surgical trays and supplies; the timeout procedure and how it is monitored; and define anesthesia capabilities and capacity for off hours.

Surveyor
Physician(s) and/or Registered Nurse

Facility Staff Present
TMD
TPM
Anesthesiologist Liaison
Orthopedic Liaison
Neurosurgery Liaison
Surgery Director/Manager
Surgical RNs

Questions/Assessment

1. Explain the process of opening an operating room (OR) for a STAT critical trauma patient during regular business hours.
2. How are the OR response times monitored and reported for designation compliance?
3. How does the process change for a case at night or on a weekend?
4. What is the process for prioritizing multiple patients needing an operating room?
5. How is surgeon availability monitored?
6. What are the expected surgeon response times, and how are these monitored?
7. How is the on-call schedule for anesthesia monitored?
8. Where is the schedule located?

9. What are the expected anesthesia response times, and how are these monitored?
10. Are Certified Registered Nurse Anesthetists (CRNAs) utilized for coverage?
11. If yes, define this process and supervision requirements.
12. How are the operating room staff educated and trained to manage trauma operative interventions?
13. What competencies and certifications are required for the OR staff?
14. Do the OR nurses have access to continuing education and conference attendance?
15. Who are the members of the OR team that provide care to critical trauma patients?
16. Is video monitoring available in the OR suite?
17. Is there a dedicated orthopedic operating room?
18. If not, describe the process in place that ensures orthopedics has a room available for any procedures necessary for extremity fracture management.
19. Are there dedicated orthopedic staff to support the orthopedic surgeons?
20. Is there a dedicated radiology technician for the OR?
21. Is there a C-Arm available?
22. Is there a dedicated neurosurgical OR?
23. Describe the equipment dedicated to that room.
24. Is there a policy in place that defines criteria for patient placement post-procedure?
25. Does the OR staff participate in disaster planning and preparedness?
26. Describe what happens if the hospital is in a mass casualty situation and a trauma patient presents to the facility.
27. What is the hospital's surge capacity preparedness?
28. Does Surgical Services provide data to the trauma PIPS?
29. How does Surgical Services participate in the PIPS process and the Trauma Operations Committee?
30. Are there currently any performance improvement initiatives being worked on in collaboration with trauma services?

Post Anesthesia Care Unit (PACU)

Purpose
To review the PACU's capabilities and capacity to care for trauma patients; the PACU hours of availability, staffing models, education, and training of staff; care management guidelines for patient monitoring; the process of provider notification for changes in patient status; and the process for patient transfer to admitted unit.

Surveyors
Physician(s) and/or Registered Nurse

Facility Staff Present

PACU Medical Director
TMD
TPM
PACU Director/Manager
PACU Educator
PACU RN(s)

Questions/Assessment

1. What equipment is available in the PACU?
2. Is there equipment for emergent resuscitation?
3. What types of trauma patients are admitted to the PACU?
4. How are PACU nurses educated and trained to manage these types of trauma patients?
5. What competencies and certifications are required for the PACU?
6. Do the PACU nurses have access to continuing education and conference attendance?
7. Explain the staffing pattern for the PACU.
8. Explain the process of preparing the PACU for a STAT critical trauma patient during regular business hours.
9. How does this process change at night or on the weekend?
10. How is the call-back schedule managed?
11. What are the expected response times, and how is this monitored?
12. Is this data presented to the Trauma Operations Committee?
13. If a patient becomes compromised or has a clinical change in the PACU, who is notified?
14. What is the typical response time?
15. How is this monitored?
16. Is this data presented to the Trauma Operations Committee?
17. Are criteria established for PACU discharge?
18. What is the nurse-to-patient ratio in the PACU?
19. Define the role of the PACU and staff during a mass casualty event.
20. How does the PACU contribute to surge capacity?
21. Does the PACU provide data to the trauma PIPS plan?
22. How does the PACU participate in the PIPS process and the Trauma Operations Committee?
23. Are there currently any performance improvement initiatives being worked on in collaboration with trauma services?

Intensive Care Unit (ICU)/Critical Care Unit (CCU)

Purpose
To review the ICU/CCU's capabilities and capacity to care for critically ill trauma patients, the triage or admission process to the ICU/CCU, the resources available to the ICU/CCU, and the trauma care management guidelines for the ICU/CCU.

Surveyors
Physician(s) and/or Registered Nurse

Facility Staff Present
TMD
TPM
ICU/CCU Surgical Medical Director or representative
ICU/CCU Director/Manager
Neurosurgery Liaison
Nurse Educator
RT
Nutritional Services
Pharmacy
Rehabilitation – PT, OT, Speech Therapy
Social Services/Case Management
Psychosocial Support

Questions/Assessment

1. Who evaluates the bed status and has the authority to open a bed for a trauma patient needing an ICU/CCU bed?
2. How long does this typically take?
3. What is the nurse-to-patient ratio?
4. Define the nursing education and credentialing expectations for the ICU/CCU nurse.
5. Do the ICU/CCU nurses have access to continuing education and attend conferences?
6. How is the ICU/CCU staff educated and trained on their role in the trauma care management guidelines?
7. What are the expectations for completing the tertiary exam?
8. If the trauma patient has a clinical change in condition, who is notified?
9. Who is notified at 3:00 am?
10. What is the expected response time?
11. How is this monitored?
12. Is this data presented to the Trauma Operations Committee?
13. If radiology overread identifies an unknown injury, how is this processed?
14. Is there dedicated RT staff assigned to ICU/CCU?
15. If so, what is their staffing model?
16. Who manages the ventilator settings in the ICU?

17. Describe the multidisciplinary rounds:
    a. Who leads the rounds?
    b. Who attends?
    c. What is the purpose of the rounds?
18. Describe the following roles in ICU/CCU:
    a. Pharmacy
    b. Nutritional services
    c. Psychosocial services
19. When does the rehabilitation team consult on a trauma patient in the ICU/CCU?
20. Define how the ICU/CCU staff are educated and trained regarding Trauma-Informed Care.
21. Who is responsible for the Screening, Brief Intervention, and Referral to Treatment (SBIRT) screening?
22. Who is responsible for the mental health screening?
23. What resources are available for the patient with the following injury:
    a. New spinal cord injury with paraplegia
    b. Traumatic Brain Injury (TBI)
    c. Amputation
24. How is the ICU/CCU patient's family integrated into their care?
25. What resources are available for the family during this event?
26. How are the ICU/CCU staff educated and trained on their role in the trauma care management guidelines?
27. Can you give an example of a care management guideline that is monitored for compliance in the ICU/CCU?
28. How is the massive transfusion procedure managed in the ICU/CCU?
29. Describe the TBI guidelines and criteria for Intracerebral Pressure (ICP) monitoring.
30. How is this monitored through the trauma PIPS process?
31. How are patients moved and monitored for procedures outside of the ICU/CCU?
32. What is the procedure for notifying the donor organization in your area?
33. Who is responsible for this notification?
34. Does the ICU/CCU participate in after-cardiac-death organ donation?
35. Are scene response patients ever directly admitted to the ICU/CCU?
36. If yes, please describe the process.
37. Describe the process if a trauma transfer is a direct admit to the ICU/CCU.
38. Who is present to evaluate that patient on their arrival?
39. Are trauma activations initiated in the ICU/CCU?
40. Does the ICU/CCU provide data to the trauma PIPS plan?

41. How does the ICU/CCU participate in the PIPS process and Trauma Operations Committee?
42. Are the Trauma Quality Improvement Program (TQIP) reports shared with the ICU/CCU staff?
43. Are there currently any performance improvement initiatives being worked on in collaboration with trauma services because of the TQIP report??
44. Does the ICU/CCU staff participate in disaster planning and preparedness?
45. How does the ICU/CCU address surge capacity and capabilities?
46. What is the plan to increase surge capacity and capabilities?

If there is a trauma patient in the ICU/CCU, the surgeon surveyor or registered nurse surveyor may interview that patient's care team.

Surgical General Unit

Purpose
To review the general unit's role in trauma management, resource availability, education and credentials, and access to rehabilitation services.

Surveyors
Physician(s) and/or Registered Nurse

Surveyors may divide and visit a surgical trauma floor, an orthopedic floor, and a neurosurgical floor as available.

Facility Staff Present
TMD
TPM
Advanced Practice Providers (APPs)
Unit Director/Manager
Orthopedic Liaison, if applicable
Neurosurgeon Liaison, if applicable
Rehabilitation – PT, OT, Speech Therapy
Spiritual Care
Psychosocial Support
Social Services/Case Management

Questions/Assessment

1. Describe the types of trauma patients cared for on the unit.
2. What are the education and credentialing requirements for the staff on the unit?
3. How have the staff been educated and trained on their role in the trauma care management guidelines?
4. Provide an example of a trauma care management guideline.
5. How is compliance with the guideline monitored?
6. Does the unit have defined expectations for trauma patient documentation?
7. Describe the expectations for the tertiary exam for patients admitted from the ED/resuscitation area to this unit.
8. How is the unit staff educated and trained regarding Trauma-Informed Care?

9. What resources are available on the unit for psychosocial support?
10. Are survivor groups, peer visitation, or pet therapy available?
11. Explain the relationship with PT, OT, and Speech Therapy on the unit.
12. Who coordinates the discharge planning?
13. Describe an instance when a trauma patient on this unit had a change in clinical condition and required to be transferred to the ICU/CCU.
14. What resources are available to respond to this type of situation?
15. If this occurred, would this event be reviewed through the PIPS process?
16. Was this event reviewed through the trauma PIPS plan?
17. Does the unit provide data to the trauma PIPS plan?
18. How does the unit participate in the PIPS process and the Trauma Operation Committee?
19. Are there currently any performance improvement initiatives being worked on in collaboration with trauma services?

Surveyor Expectations

The surveyors will return to the medical record review room within 45 - 60 minutes and be prepared to share a summary of their findings with the lead surveyor. The lead surveyor will define any outstanding issues or additional survey actions needed.

APPENDIX I: EXAMPLES OF GROUP INTERVIEW

Trauma Group Interview

Group interviews are an excellent method for conducting interviews and validating designation requirements are met. The surveyors open the discussion with a brief introduction and explain the purpose of the discussion is to evaluate the facility's response and continuum of care needs for trauma care. Surveyors explain that they will direct the questions to those present

The surveyors adjust the scenario based on the facility's services and can define the needs of the patients based on the scenario.

The lead surveyor may direct the survey teams to utilize the same scenario for the physician interviews and the nursing continuum of care interviews. This allows the surveyors to compare answers and feedback from the interviews.

Listed are questions designed to stimulate the interview process and engage the physicians present.

Note: The Trauma Medical Director should avoid answering the questions.

Example Scenario:

A family of three was traveling to church around 10:00 am on Sunday when their small sedan was hit at the driver's side door by a speeding pickup truck running a red light. The driver, who appears to be in his 40s, was not wearing a seatbelt. This patient has a loss of consciousness; the left hip and femur are trapped by the intrusion into the compartment. The femur appears to be an open compound fracture with bleeding at the scene.

The second patient is an 85 year-old female in the front seat passenger side. She was wearing a seatbelt. She has a hematoma to her right parietal area with some bleeding. She has a deformed left lower leg. She states she is having chest pain.

The third passenger is a three-year-old female who is in a child protective seat on the right rear side. The seat appears to have broken loose during the crash and is trapped between the front and rear seats.

911 has been called.

EMS has arrived on the scene.

The surveyors utilize this scenario to discuss the field triage of the patients and how the hospital prepares to receive these patients.

Physician Group Interview

Surveyors
Lead Trauma Surgeon
Emergency Medicine Physician

1. Define the process of revising your trauma activation guidelines.
2. In the scenario presented, how would trauma activations occur?

3. What is the relationship between the prehospital providers and this facility?
4. Who from the program is involved in the prehospital protocol development and prehospital performance improvement process?
5. How is prehospital feedback regarding patients provided?
6. In the trauma activations, who manages the patient's airway?
7. Describe the relationship and responsibilities between emergency medicine and the trauma service in a trauma resuscitation.
8. How are the trauma management guidelines produced and implemented?
9. Who decides what aspects of the guidelines will be monitored through the trauma PIPS process?
10. How are the orthopedic trauma guidelines developed? How are they implemented? How are the high acuity injuries that require a 30-minute response from orthopedics identified and integrated into the trauma activation criteria? How is this monitored in the trauma PIPS plan?
11. How are the neurosurgical trauma guidelines developed? How are they implemented? How are the high acuity injuries that require a 30-minute response from neurosurgery identified and integrated into the trauma management guidelines and activation criteria? How is this monitored through the trauma PIPS plan?
12. Define your facility's pediatric trauma guidelines. Are pediatric trauma patients admitted to the facility or typically transferred?
13. If transferred, who manages the transfer process?
14. Are geriatric trauma management guidelines in place?
15. What are the criteria for admitting geriatric trauma patients to the trauma services or to the hospitalist service?
16. How is the hospitalist service integrated into the trauma program?
17. How is this process monitored through the PI process?
18. If the resuscitation team identifies a need for emergent Interventional Radiology, how is it coordinated? Who notifies the IR radiologist? How are response times monitored?
19. If the resuscitation team identifies a need for emergent operative intervention, define the process of opening an OR STAT.
20. How is anesthesia notified of a STAT trauma OR case?
21. If it is during the night, how is this managed?
22. How is equipment in the OR organized?
23. Are there dedicated trauma OR rooms? Orthopedic rooms? Neurosurgery rooms?
24. Define the process of obtaining STAT blood in the OR. Activating an MTP.
25. How do the operating surgeon and the anesthesiologist communicate during a case to coordinate the patient's resuscitation?
26. Describe the decisions and guidelines in place to admit the trauma patient to the ICU versus the PACU.

27. What is the surgical coverage for the ICU?

28. What is the role of advanced practice providers in the ICU?

29. What are the ICU's capabilities and resources for managing a critical trauma patient? Orthopedic patient?

30. What are the ICU's capabilities and resources for managing a critical trauma neurosurgical patient? Define the guidelines in place for TBI management. Define the guidelines in place for spinal cord injury.

31. How is ventilator management in the ICU defined, and the relationship between the ICU service and the trauma service?

32. What clinical scenario requires the physical presence of the trauma-attending surgeon?

33. If a patient has an elevated ICP, who is notified?

34. What clinical scenario requires the physical presence of the neurosurgeon?

35. Who completes the tertiary exam?

36. Who manages the ICU multidisciplinary rounds? Who participates in these rounds? What lessons have been gained from these rounds?

37. How is wound care addressed in the ICU? Is there a wound service available?

38. Are bedside procedures performed in the ICU? If yes, can you describe the process?

39. If consulted in the ICU, when do rehabilitation services evaluate the patient?

40. Define the psychological support services available for the ICU patient. Family members?

41. Are there established ICU discharge criteria? How are these defined?

42. Is there a dedicated trauma unit? If yes, define the unit's capabilities and resources.

43. Is there a dedicated orthopedic unit? If yes, define the unit's capabilities and resources.

44. Is there a dedicated neurosurgical unit? If yes, define the unit's capabilities and resources.

45. Are advanced practice providers integrated with these teams or specific units? If yes, define their role.

46. Describe the criteria for determining which patients receive rehab consults (PT, OT, Speech Therapy) and are not admitted to a rehabilitation facility. Who makes this determination?

47. What are the barriers to discharge planning?

48. Are there obstacles that impede the coordination of care?

49. How do the following specialties interact in the care of the trauma patient?

    a. Trauma
    b. Emergency medicine
    c. Orthopedics
    d. Neurosurgery
    e. Critical Care – ICU
    f. Radiology – including Interventional Radiology

50. How is trauma peer review organized?

a. How do the specialty services know they have a case that is being reviewed in peer review?
b. How do the specialty services receive feedback from the case discussions?
c. Who communicates the action decisions to the specialty service?

Thank the participants for their time and commitment to the designation program.

APPENDIX J: DESIGNATION SURVEY FEEDBACK FORM

Please complete this designation survey process feedback form and send the completed form to DSHS.EMS-TRAUMA@dshs.texas.gov.

Go to the next page to view the form.

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

Designation Survey Feedback

Please complete this designation survey feedback form and send the completed form to Jorie Klein, MSN, MHA, BSN, RN, Director of EMS Trauma Systems Section at jorie.klein@dshs.texas.gov.

Facility Surveyed: _____

Type of Survey: Trauma ☐ Stroke ☐ Maternal ☐ Neonatal ☐

Level: I ☐ II ☐ III ☐ IV ☐

Survey Option: Virtual ☐ In-Person ☐ Hybrid ☐

Survey Organization: _____

List Surveyors:

Recommendations to improve the survey planning process:

Recommendations to improve the medical record review process:

Recommendations to improve day one of the survey:

Recommendations to improve day two of the survey:

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

Designation Survey Feedback

Recommendations to improve surveyor performance:

Recommendations to improve surveyor communication:

Recommendations to improve the survey summary report:

Recommendations to improve communication with the department:

Recommendations to improve the department's performance:

Recommendations to improve the overall survey process:

Thank you taking time to complete this feedback form. We appreciate your time and willingness to provide recommendations to improve the survey process.

APPENDIX K: STAFFING CONSIDERATIONS

Designation Program Staffing Considerations

Program Management/ Oversight	Patient Volume	PI Medical Record Reviews	Registry/Data Abstraction/ Entry/Reportable Data	In-Patient Rounding/ Follow-up/PI Reviews	Committee Preparedness/ Management/ Oversight	Public Awareness/ Outreach Education/ Prevention	RAC Participation	Staffing Considerations
X	250	X	X	X	X	X	X	1 FTE
X	500	X	X	X	X	X	X	1.25 FTEs
X	750	X	X	X	X	X	X	1.5 FTEs plus 1 Registrar
X	1000	X	X	X	X	X	X	2 FTEs Plus 2 Registrars
X	1500	X	X	X	X	X	X	2.5 FTEs plus 2.5 Registrars
X	2000	X	X	X	X	X	X	3 FTEs plus 3 Registrars
X	2500	X	X	X	X	X	X	3.5 FTEs plus 3.5 Registrars
X	3000	X	X	X	X	X	X	4 FTEs plus 4 Registrars; plus dedicated OE/IP staff
X	3500	X	X	X	X	X	X	4.5 FTEs plus 4.5 Registrars; plus OE/IP staff
X	4000	X	X	X	X	X	X	5 FTEs plus 5 Registrars; plus OE/IP staff
X	4500	X	X	X	X	X	X	5.5 FTEs plus 5.5 Registrars; plus OE/IP staff
X	5000	X	X	X	X	X	X	6 FTEs plus 6 Registrars; plus OE/IP staff
X	5500	X	X	X	X	X	X	6.5 FTEs plus 6.5 Registrars; plus OE/IP staff
X	6000	X	X	X	X	X	X	7 FTEs plus 7 Registrars; plus OE/IP staff
Outreach Education (OE)/Injury Prevention (IP) Note: If you do not currently capture registry data, you need to eliminate the registry FTEs.								

TEXAS
Health and Human
Services

Texas Department of State
Health Services