CONSUMER PROTECTION DIVISION
EMS TRAUMA SYSTEMS SECTION

TEXAS DESIGNATION SURVEY GUIDELINES

TEXAS Health and Human Services
Texas Department of State Health Services

JULY 2023

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GOALS OF DESIGNATION SURVEY GUIDELINES

The goals of the designation survey guidelines are to establish a standardized structure and processes for the designation surveys in Texas. The objectives are to establish consistency in the types and levels of surveys and to provide guidance for the survey planning process and elements of the survey.

The designation survey guidelines are designed to assist the facility administrators, designation 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 designation surveys to provide clarity and define consistent expectations in the survey processes.

Questions specific to the designation survey guidelines are directed to **DSHS.EMS-TRAUMA@dshs.texas.gov**.

Survey Expectations

Each designated facility in Texas must have an evaluation process to validate that the facility has documented evidence the requirements for designation are met. This validation process is accomplished by a facility survey, onsite or virtually.

Facilities are required to contact a department-approved survey organization and schedule their designation survey. It is the facility's choice which survey organization is used unless it is defined in the **Texas Administrative Code** (TAC).

Rural facilities that meet the parameters to have a virtual survey with the department will contact the department to schedule their 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 also have evidence of credentialing as a surveyor by the survey

organization. Surveyors should observe a survey and then assist with a survey while being mentored by an experienced surveyor. The department-approved survey organization must have evidence of surveyor training available if requested by the department.

Designation Survey Overview

The purpose of the designation survey is to validate the designation requirements are met. Facilities pursuing designation must demonstrate that all requirements for designation are met. It is important to note that the survey process verifies how the facility demonstrated meeting the requirements. Plans for meeting the requirements are not considered during a survey.

The survey team composition is defined by the types and levels of designation requested. The TAC rules define the survey team composition for each designation program. 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. Surveys completed with a surveyor(s) that has a known potential or actual conflict of interest will not be accepted by the department. If the facility has any questions regarding a conflict of interest, they can refer back to the specific TAC rule language or contact the department for clarification. See **Appendix F** for the recommended survey team composition and recommended conflict of interest form.

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

FACILITY DESIGNATION SURVEY PLANNING GUIDELINES

The purpose of the survey is to determine if the facility requesting a level of designation meets the requirements specific to the type and level of designation they are seeking. This is applicable to facilities seeking initial designation or renewal of designation. The agreement between the department-approved survey organization and the facility must include measures to ensure the environment is conducive to the survey process and

fosters a cooperative process between the surveyors and the facility's program staff.

Evidence designation requirements are met determined by:

1. Consistent clinical care that meets or exceeds the established management guidelines and current evidence-based practice, evaluated by the care documentation in the medical records.
2. Concurrent, effective performance improvement and patient safety (PIPS)/quality assessment and performance improvement (QAPI) plan that is integrated into the hospital's processes and regional processes and aligns with the department's system performance improvement plan.
3. Documented policies, procedures, protocols, and management guidelines specific to the population served and specific to the facility and resources available at the facility.
4. Evidence of data management and submission of required data to DSHS within the specified timelines.
5. Validation that required resources are available and requirements met by appropriate responses from specific interviews with program staff, medical staff, administrative leaders, and key clinical individuals participating in the designation program.,
6. Review of outreach education and training programs provided by the facility and prevention programs if required by the TAC rule.
7. Documented regional participation at required committees.
8. Evidence of regional and hospital participation by the Medical Director and Program Manager in disaster management and response training.
9. Documented evidence that all designation requirements are met.

The survey may be halted if the surveyor's capacity to complete the survey responsibilities is impeded. Examples of events 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 performance reviews, or data due to technical performance or access issues.
3. Falsifying 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 staff has 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

Contacting the Survey Organization

The facility seeking designation or renewal of designation is responsible for contacting an appropriate department-approved survey organization of their choice to schedule their survey. It is strongly recommended that the facility contact the survey organization a minimum of 18 months before the desired survey date. The survey date needs to ensure that receipt, review, and development of a plan of correction for identified opportunities may be accomplished for application submission. The facility must submit the entire 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.

Survey Preparation

The facility will focus on survey planning and preparation. This includes the completion of the Designation Assessment Questionnaire (DAQ). The DAQ must be submitted to the department and selected survey organization a minimum of 45 days before the scheduled survey. The DAQ will not be accepted if it is received less than 45 days prior to the scheduled survey. The facility will include the DAQ in a shared file created by the facility that the department and surveyors have access to for review. The facility's Chief Nursing Officer (CNO), designation program staff, Information Technology (IT) staff, and program's performance improvement (PI)/quality assessment and performance improvement (QAPI) staff will approve the shared file to comply with the required rules and laws related to confidentiality. (**Note**: If the rule defines a facility must use a specific survey organization, that survey organization's questionnaire and processes must be followed in addition to the department process.)

It is important to note that 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 leaders and staff are responsible for leading the survey and responding to all questions from the surveyors.

Preparing Survey Documentation

The facility's leadership and program 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 immediately available to facilitate the survey process when on site. It is important to note the oldest documents cannot be greater than 12 months prior to the survey. The facility must prepare the following documents for the survey:

1. Evidence the medical director and program manager are participating in the regional advisory council (RAC) or perinatal care region (PCR) and meeting the membership requirements for the entire designation cycle (two or three years, depending on the program).
2. The designation program's organizational chart includes the reporting structure and number of full-time and part-time equivalents (FTEs and PTEs).
3. The facility's organizational chart reflects the reporting structure of the designated program.
4. The operational budget that supports the designation program.
5. The designation program's performance improvement patient safety (PIPS) plan or quality assessment performance improvement (QAPI) plan.
6. The program's annual PIPS/QAPI plan summaries (dashboards) for the designation cycle. Include the list of common screening events utilized by the facility. See **Appendix B** for a list of common screening events.
7. A minimum of 12 months of the specific committee or oversight process attendance rosters, compliance with attendance, and committee or oversight process minutes.
8. The current designated program's operational plan.
9. Job Descriptions (as applicable)
    a. The administrator responsible for the designation program
    b. Medical Director
    c. Program Manager
    d. PIPS/QAPI Personnel (assisting the designation program)

e. Lead Registrar/Data Manager as applicable
f. Advanced Practice Providers participating in the designation program
g. Outreach Coordinator (if separate from one of the other positions)
h. Other personnel dedicated to the designation program (PI Coordinators, Injury Prevention Coordinators)
i. Other support personnel (Lactation Specialist, Child Life Specialist)
j. Physician Liaisons (as applicable)
k. Transport Medical Director (as applicable)

10. A Registry or data management plan. See **Appendix C** for registry or data management inclusion criteria.
    a. A maternal data management plan and benchmarking process, including data elements used in the process.
    b. A neonatal data management plan and benchmarking process, including data elements used in the process.
    c. A stroke registry or data management plan with defined criteria and any benchmarking reports specific to the designation program (including any participation with "Get with the Guidelines").
    d. A trauma registry or data management plan defining inclusion criteria and any benchmarking reports specific to the designation program.
11. Trauma facilities must have documented evidence of quarterly submissions to the State Trauma Registry. Documents reflecting the data validation and corrective actions as appropriate for the past 12 months or designation survey timeline.
12. Level III and IV Neonatal programs will have data reflecting participation in the benchmarking program of their choice.
13. Evidence of the facility's support or commitment to the designation program (Resolutions as applicable).
14. The documented management guidelines, evidence-based practice, or best-practice guidelines for the population served.
15. All program-related policies, procedures, protocols, and guidelines, including transfer and diversion guidelines. Diversion documentation must include the hours of diversion, the reason for diversion, and

corrective actions taken if diversion times are lasting greater than 12 hours at a time or greater than five percent of the month or quarter and the resolution.

16. 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.
17. 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.
18. Processes and documentation that reflect how the facility monitors designation requirements to ensure they are met must be available for the surveyors if not included in the documented PIPS / QAPI plan.
19. Staff orientation and designation-related educational requirements, certifications, and continuing education records for areas providing care to the specific patient population of the program.
20. Documentation of Medical Staff and Advanced Practice Provider (APP) credentialing and required CME or continuing education for providers who participate in or provide care for the program's patient population.
21. A list of all participating medical staff in the program, including liaisons, specialty service physicians, and advanced practice providers.
22. A list of selected medical records for review as defined by the specific designation requested.
23. Map of referral area, identifying rural areas or transport challenges.
24. Documented evidence of the program's disaster training, evaluation, and evidence the program medical director and program manager are participating in system planning.
25. The facility will prepare the data for the survey in reverse-chronological order, starting with the most recent months and moving backward.
26. Program staff will dedicate time to select the recommended medical records for the survey and prepare the designation medical record review face sheet and the discharge summary documents. (See **Appendix E**)

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 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 hospital's Chief of Information Technology, Chief of Quality, and Chief Nursing Officer.
    e. Documents must be available to share electronically with the survey team and department staff a minimum of 45 days prior to the survey. 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 all confidentiality forms signed by the survey team a minimum of 45 days prior to the survey.
2. Program staff 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 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
    f. Medical record preparation
    g. Administrative overview and support of the program
    h. **Note**: if a trauma facility is requesting an alternate pathway for a physician, this must be reviewed in the pre-conference call.

3. The facility will develop a process to orient the surveyors to the electronic medical record and the PIPS/QAPI 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 electronic medical record (EMR) and PIPS or QAPI documentation, are completed a minimum of 45 days before the survey date.
5. Each surveyor or department reviewer will need a defined electronic medical record navigator who has the skills, proficiency, and access to all areas, including records needed to complete a medical record review during the survey process, and is knowledgeable of the program's PIPS/QAPI and data management process. (**Note**: Maternal medical records will need access to fetal heart monitoring records and trauma registry access for trauma facilities).
6. The facility will prepare a folder for each of the potential survey medical records for review that includes all associated PI/QAPI documentation, associated management guidelines, and a data abstraction profile for benchmarking, PI, QAPI, or database entry. It is important to note that 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 during the medical record review. 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 note, 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 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 ten medical record reviews during the survey.)
8. The facility should review its previous designation surveys and survey outcomes and be prepared to discuss improvements made to address the survey findings.
9. For trauma surveys, the department 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, ED disposition, hospital discharge, and the incidence of missing data available. These reports are shared with the site survey team as necessary.

10. Trauma facilities will include an approved Alternate Pathway if required for a physician. Please include this in the shared file documents 45 days prior to the survey.
11. The facility will prepare a folder for the surveyors and designation staff that includes the following information:
    a. Survey agenda
    b. Name and title of attendees at each session of the survey
    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
12. The program leaders are responsible for including the survey date on the calendars of the hospital CEO, CNO, CFO, COO, CMO, all physicians taking call for the designation program, physician liaisons, leaders of all departments, and nursing units that provide care to the patient population. Educators, social services, rehabilitation, laboratory, radiology, and security need to be included in this notification and pertinent meeting request.
13. The program leaders are responsible for ensuring that the Chief of Information Technology (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 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 will plan for the meals during the survey.

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 be greater than 12 months prior to the survey date. 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 it is a focused review or re-review of the program, the medical records review will not include records before the original survey date. Each surveyor is required to complete ten medical record reviews.

The room for medical record review must be large enough to accommodate the survey team, department staff, and required program staff. Each surveyor must have two computer monitors with a minimum of a 22-inch screen and two keyboards. Each keyboard must have a mouse. The review space must accommodate the surveyor and the navigator. The room must have reliable internet capability. The program medical director, program manager, data management staff, and PI personnel must stay in the room to answer questions. If other key individuals stay in the room, the space must accommodate these additional individuals. All individuals who remain in the room must be cognizant of keeping talking 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.

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

The medical director and program manager must have the ability to locate individuals quickly for interviews and to answer questions related to a medical record review. A separate room for individual interviews must be near the medical record review room.

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 go to sleep 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 chart 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 chart in a practice session with the program manager 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 interview room location.

Exit Conference Planning

The facility and program staff 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. In some facilities, the executive team includes members from the Board of Managers. The facility may choose to invite members of their local EMS and Regional Advisory Council (RAC)/Perinatal Care Region (PCR) to the exit conference. The facility needs to 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.

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

Representatives from the media are not allowed to attend the exit conference. Information regarding the designation survey should not be released until the facility has 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 is met, these documents must be sent to the lead surveyor within three business days of the completion of the virtual or onsite survey.

If the facility has four or more designation requirements that are not met based on the exit survey findings, the facility must call the department within the next ten business days to discuss an action plan.

The facility will send the survey summary report, medical record reviews, and any additional documents to the department following the TAC requirements. The facility will submit these documents to the department within 90 days of the survey date. If the survey organization identifies requirements are not met, the facility must include their plan of correction 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 monitored. The facility must provide documentation that the corrective actions are implemented within 90 days of the survey date.

It is important to note the facility's survey application will not be processed until all documents are received. This includes the designation application fee.

Each facility will be asked to complete a survey feedback form and submit the completed document to the department within 30 days of the site survey. See **Appendix J** Designation Survey Feedback Form.

Media Communication and Release

As previously stated, media representatives are not included in the facility's site survey and not included in the exit conference of the survey. There are no exceptions. Media releases and communication scheduled by the facility should 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, or department if they identify issues related to the survey planning, survey, or survey follow-up. All feedback should be submitted to the Director of the EMS-Trauma Systems Section. Feedback will be reviewed by the appropriate perinatal appeal panel members or the trauma designation review committee. A feedback summary related to the stroke designation process will be reviewed by the department at the

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

Designation Application Process

After the survey, the facility must complete an application for the requested level of designation. The application packet includes an application form, designation fee, evidence of RAC/PCR participation, a designation survey summary report and medical record reviews, a designation facility self-assessment, and any other documents stated in the rule. The application packet must be completed and submitted to the department within 90 days of the survey and a minimum of 90 days prior to the expiration of their current designation. Application documents will be sent electronically to: **DSHS.EMS-TRAUMA@dshs.texas.gov**. The designation fee appropriate for the type and level of designation must be submitted to the Revenue Management Unit – Cash Receipts Branch Texas Department of State Health Services with a remittance form. The application will not be processed until the fee and all required documents are received.

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 for specific issues. 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 survey. Consultative surveys are between the facility and the consultant(s). These consultation reports are not included in the survey process or 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 designation surveys in Texas must complete the department application every four years. The initial application to be recognized as a department-approved survey organization needs to be completed and sent to the department by December 1, 2023. Subsequently, renewal applications will be accepted between January 1st and January 31st in the following years. Department-approved survey organizations must complete a new application every four years following the same process. The survey organization re-application process timeline is January 1st through the 20th. See **Appendix G** for the Survey Organization Application.

The survey organization must define their selection process for surveyors ensuring they follow the department guidelines and define how these individuals are trained and credentialed to complete the designation surveys. The training must include an overview of the specific TAC rules for designation and how the surveyor evaluates the documentation that validates the requirements are met. This training must include how to complete the organization's survey documents that meet the department's requirements. Each surveyor must have documented evidence of completing a PI or QAPI course specific to the designation type they are surveying. Surveyors must have led or participated in their facility's designation survey and have completed two successful designation reviews. Surveyors must first observe a designation survey and then assist in a designation survey while being mentored by a senior surveyor evaluator. Each surveyor must have evidence of completing two surveys annually to maintain competencies. (The maternal surveyors will not be accountable for completing two successful surveys until January of 2026.)

The survey organization is responsible for the development of the survey tools they utilize and ensuring these documents meet the department requirements and capture all essential elements of the survey process and TAC requirements.

The survey organization must have an oversight and performance improvement 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 during a survey. Each surveyor must complete ten medical record review summaries during the survey and complete survey assignments outlined by the lead surveyor. The surveyor must demonstrate 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, it is the survey organization's responsibility to address issues or concerns with the surveyor. The survey organization must define how this occurs in the application process. Failure to address or assess a designation requirement, 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 on-site and follow the recommended schedule.

It is the facility's choice for a re-designation survey to be onsite, virtual, or hybrid. It is strongly recommended that the survey schedule for facilities having their third designation review with no previous contingencies or issues in the last survey utilize a one-day survey agenda. The facility and the department-approved survey organization can utilize a hybrid survey schedule with virtual and onsite processes.

The department may determine that an onsite survey is required for a facility.

Examples of this are having the program share their documentation in advance for the surveyors to review. The pre-survey conference call can be utilized to discuss the documents and identify any outstanding items needed. The survey team reviews these documents in advance to gain an understanding of the program's resources and capabilities. This allows the survey team to focus on the medical record reviews while onsite.

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 the survey organization, the survey organization may define the survey schedule. The schedule must consider the impact on the hospital and any burden of overtime for staff. The schedule must be accepted by the hospital CNO, program medical director, and program manager.

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. It is recommended that a one-day schedule be utilized for facilities completing their third designation survey who did not have any previous designation contingencies.

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. 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 and all surveyors complete their medical record reviews prior to the pre-survey conference call. (Required documents are located under “Preparing Survey Documents” on page 9.)

Pre-Survey Conference Call

The purpose of the survey pre-conference call is to review all documents placed in the shared file to ensure all necessary documents are received and plan for the actual survey. The pre-conference call allows the surveyors an opportunity to ask questions and clarify information in the documents. The facility will review its improvements and facility enhancements since the last designation survey and review any key staff changes. The surveyors will finalize the medical records selected for review after completing the review of the medical record face sheets, admission notes, and discharge summary.

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

The lead surveyor will define the agenda and any items to be reviewed by the facility during the survey opening conference.

Survey Opening Conference

The program leaders are responsible for ensuring the reserved conference room for the onsite or hybrid survey is an appropriately sized conference room, and it must have sufficient internet and electrical support. The conference room must have appropriate 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 the facility staff. Preparation for the survey begins with the review of the facility's designation application questionnaire (DAQ) and the documents placed in the shared file posted 45 days before the survey. Surveyors should arrive with their list of questions or situations that need further clarification and be prepared to review these items with the facility's staff during the opening conference.

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

Opening Survey Comments

The facility has until 0830 to provide an overview of the facility, the history of the designation program, and its role in the region. The facility will provide a high-level review of the program's performance improvement (PI)/quality assessment performance improvement (QAPI) structure and how event resolution is determined. An overview of the program's designation performance dashboard is presented at this conference. The facility leaders provide an overview of the requirements not met and identified weaknesses. The program provides a synopsis of the corrective actions to meet the requirement(s) and how this has been sustained. The facility reviews its processes for disaster preparedness and outcomes of the last event or exercise. Lastly, the facility may provide a virtual tour of the facility and highlight any recent program improvements.

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 performance improvement/quality assessment performance improvement plan
6. Current performance improvement/quality assessment performance improvement and review the program's performance dashboard
7. Disaster preparedness activities
8. Overview of the facility, demonstrating key areas involved in the designation program (optional)

Facility Tour

If the hospital is having its initial designation review or upgrading its level of designation, the hospital will complete the facility tour and complete interviews during the facility walk-through assessment. The purpose of the facility walk-through assessment is for the surveyors to gain an understanding of the following:

1. The flow of the designation program's patient population through the facility.
2. Facility's commitment to providing necessary resources and equipment for the care of the specific patient population.
3. Evaluate that facility's bedside staff readiness to care for the specific patient population, their knowledge, education, and their role in the designation program, and performance improvement/quality assessment performance improvement.
4. Evaluate specific designation requirements.

Group interviews

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

The next phase of the survey is divided into group discussions. 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 and core physicians of the designation program, the consulting services that support the designation program, and the defined program liaisons. The Chief Medical Officer, Chief of Staff, or Chair of the Medical Executive Committee typically attends this group interview. The nursing and clinical services continuum of care group includes the program manager and the nursing leaders, educators, and staff, as well as the clinical support areas for the lab, blood bank, radiology, respiratory therapy, rehabilitation (PT, OT, Speech therapy), psychosocial support staff, social workers, discharge planners, and other support staff. 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.

In designated facilities with limited resources, the group interviews integrate the physicians, nurses, and clinical services.

These scenario-based questions require planning and preparation to ensure they are organized, pertinent, and relative to the designation program's activity and volume, as evidenced in the questionnaire. The scenario-based questions for the physician and continuum of care groups should be similar and appropriate to the level of designation to evaluate clinical processes and resources available. See **Appendix I** for examples of the group interview process.

The group interviews may be virtual or in-person. Virtual meetings require an adequate platform with stable internet to accommodate the number of participants and scheduling needs. In addition, a representative from IT must assist in coordinating the meetings. 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 to the meeting.

Medical Record Review

Most of the survey time is utilized for medical record reviews. The purpose of the medical record review is to evaluate clinical care provided to the patients, the PI/QAPI reviews initiated by the facility, and patient outcomes. Clinical care is reviewed from pre-arrival or prehospital through discharge planning and follow-up as appropriate. The clinical 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 and the facility follows established management guidelines. The surveyor must be compliant with all HIPAA measures during the entire survey process.

The medical record review includes the surveyor's review of PIPS/QAPI initiatives. This includes the identification of variances in care or events, level of harm produced by the event, levels of review, corrective actions taken, and measures to reach and maintain event resolution. In addition, meeting minutes are reviewed as an element of the performance reviews. Transfer follow-up letters and autopsy reports, as available, are also reviewed at the time of the medical record reviews.

In the review of the PI/QAPI plan and identified events, the surveyor must have access to and evaluate the following:

1. Facility's timelines to identify events
2. The level of harm caused by the event or variance
3. When appropriate, an analysis of the frequency of the event
4. The level of review
5. Defined opportunities for improvement
6. Identified and implemented a corrective action plan
7. Action plan outcomes
8. Appropriate committee review with attendance and meeting minutes specific to the case
9. Data to support event resolution
10. Transfer follow-up letters
11. Autopsy reports
12. Feedback from referrals or other requested reviews

As each medical record is reviewed, the surveyor must have the file that contains the PI/QAPI documentation for that specific case, minutes from committee meetings or conferences of the case review, any follow-up

documentation, any data profiles, and associated management guidelines specific to the case.

The surveyor will identify any outstanding medical record issues and inform the assigned program staff member. This allows the program to be aware of these issues and, when possible, resolve 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 program's PIPS/QAPI process. The navigator must be able to explain documentation requirements, management guidelines, and questions related to the PIPS or QAPI process.

In each phase of care, the surveyor is expected to determine if the facility's documented management guidelines were followed, if the designation requirements were followed, and if any PIPS/QAPI events were identified. Once an event is identified, the surveyor reviews the facility's associated PIPS/QAPI documentation and how the event review was processed by the facility. The surveyor will list any PIPS/QAPI events identified by them that were not identified by the facility. This information is shared with the navigator. The navigator is responsible for making the medical director, program manager, or their designee aware.

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 define any issues that need follow-up or further clarification.

The lead surveyor will request time with the facility's program administrator, medical director, and program manager 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.

Medical Record Review Continues

The medical record review will continue until ≈1630.

Closed Survey Team Discussion

This is a closed meeting held in the medical record review room. Surveyors and the designation staff will 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, and strengths are generated to share with the facility's program administrator, medical director, and program manager.

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.

Note: It is strongly recommended in facilities that are completing their third designation survey, the survey organization will define a schedule that completes the survey in one day. The following survey schedule is recommended for facilities completing their second designation survey or for a facility that had previous contingencies.

Program Update

The survey team will provide an update to the facility's program administrator, medical director, and program manager. The update will define the potential requirements not met and what is needed to validate requirements are met. The survey team will also review the opportunities for improvement and the strengths of the program.

(Note: The site survey timelines may alter based on the survey readiness, medical record reviews, and unanticipated events that occur during the survey. If more time is needed to complete the medical records or document review, the lead surveyor is responsible for adjusting the schedule and notifying the program staff. 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 Survey

0715 to 0930

Medical Record Review Continues

Surveyors must complete the ten 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.

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, and strengths. The team will list recommendations for the program. The lead surveyor is responsible for ensuring the designation requirements checklist is completed.

Exit Conference 1030 to 1100

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 members have completed your designation survey. Based on our review, we will share our survey findings beginning with the potential requirements not met, opportunities for improvement, strengths of the program, best practices identified, and regional integration and participation. We will provide you with our recommendations to improve or further develop your program.

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 a designation survey summary report and forward the report and all medical record reviews to the facility's 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.

The lead surveyor and survey team will review the following:

- Requirements not met
- Opportunities for improvement
- Strengths
- Identified best practices
- Regional integration and participation
- 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:

- Program medical director
- Program manager
- 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.

Designation is determined and awarded by the department. When available, the department staff will comment on the review of the application and turnaround time.

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 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 PIPS/QAPI reviews need to be integrated into the survey 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 three business days of completing the designation survey.

The completed survey summary report is sent to the facility within 30 days of the survey date. The survey organization may require the surveyor to submit the survey summary report to the organization, and they will send the final report to the facility.

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 two surveys annually.
5. Surveyor documentation in the designation survey summary report adequately reflects the requirements that are met.
6. Surveyor documentation in the designation survey summary report adequately reflects when requirements are not met and links this back to associated medical record reviews.
7. Surveyor documentation adequately reflects information gained in the medical record reviews.
    a. PI/QAPI issues
    b. Phases of care review
    c. Management guidelines followed
    d. Designation requirements are met or not met, and why

The lead surveyor requires the ability to collate information from all of the surveyor's documentation to reflect a concise reflection of the survey summary. The survey summary must reflect requirements not met, program strengths, opportunities for improvement, identified best practices, regional integration and participation, and recommendations.

If the survey organization's performance improvement process identifies opportunities for improvement or the department identifies opportunities for improvement, the survey organization must have documentation and evidence that reflects how these opportunities were addressed.

Surveyor Expectations

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

All current surveyors for approved survey organizations will automatically be approved surveyors. Their only requirement is to validate they have taken a PIPS/QAPI course specific to the surveys they are completing, attend the DSHS surveyor training, and complete a minimum of two surveys annually.

These surveyors must be in good standing with the survey-organizations' review of their survey reports.

Recruited surveyors after January 1, 2024, must meet the criteria to be a designated surveyors. Surveyors are required to be active members of a designated program at the same or higher level of designation and participate in the facility's PIPS/QAPI processes. The surveyor must have documented evidence of completing a PIPS/QAPI course. The surveyor must be from a facility that has had a minimum of two successful designation reviews (does not include a contingent or probationary designation). Maternal surveyors will be waived from this expectation because the maternal redesignation surveys are not slated to begin until 2023. The next step is to complete the surveyor application for the department-approved survey organization for consideration. The third step, if selected by the survey organization, is to 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 an updated training module every four years or when new rules or survey guidelines have been introduced.

A key element of surveyor training is to monitor a survey with a defined surveyor mentor. In this capacity, the individual training to be a surveyor is expected to review medical records and participate in the series of survey questions with the guidance of an experienced surveyor that mentors the surveyor recruit through the process and critiques their performance at the end of the survey. The critique form will be retained by the survey organization. If the mentor signs off that the surveyor expectations are met, the next step is to serve as a survey team member and be monitored by the lead surveyor.

Surveyor Requirements

1. Experience in leading a facility through two successful designation surveys (contingent or probationary designation surveys do not meet this requirement).
2. The lead physician is in a lead role in their facility, actively participating in clinical care in a specific designated facility, is board-certified, and actively participates in PIPS/QAPI processes.
3. Other physician surveyors must actively participate in their program's PIPS/QAPI process.

4. Program Manager that is at a minimum BSN prepared and actively participating in the clinical care oversight of a specific designated facility, including the oversight of the PIPS/QAPI process and outcome reviews.
5. Surveyors outside of Texas must be from the same or higher level of verified/designated facility or from a state with a certification program or categorization program requiring a survey process, and their facility has had two successful designation surveys.
6. Individuals who meet the surveyor role requirements but have retired can survey for three years after retirement before being rotated off the surveyor panel.
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 or maintain associated certifications and 16 hours of CME or CEUs annually specific to the programs they are surveying.
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. Orthopedic Surgeons and Neurosurgeons must have a minimum of 5 years of experience in the role of program liaison, actively participate in clinical care and oversight in a designated trauma facility, and be board-certified.
10. Neurologists must have a minimum of 5 years of experience in the role of program liaison, actively participate in clinical care, oversight, and performance improvement processes in a designated stroke facility, and be board-certified.
11. Must have completed a PIPS/QAPI course in the last 4 years and not received any weakness or requirements not met related to PIPS/QAPI in their facility's site survey.
12. Trauma program manager surveyors must have completed an AAAM Injury Scoring Course.
13. In-state surveyors attend and participate in the Governor's EMS Trauma Advisory Council (GETAC) or Committees or the Perinatal Advisory Council (PAC) meetings.
14. Must have documented evidence of completing the survey organization's surveyor training course.

15. Must complete a successful intern survey with an assigned surveyor mentor that completes a critique at the end of the survey.
16. Must complete a minimum of two surveys annually to remain current.
17. 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.
18. Must maintain confidentiality with any assigned surveys, prior to the survey and after the survey, and not disclose they surveyed that specific hospital or discuss any findings specific to a facility unless it is related to the survey organization's performance improvement process.
19. 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 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/QAPI 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, strengths, identified best practices, regional integration and participation, and providing pertinent recommendations;
8. Expectations and timelines for completing the written survey summary report; and

9. Expectations and timelines for completing ten medical record reviews and summaries.

Professionalism

All surveyors must continuously maintain professional behavior. If you are having issues during the survey process, you 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 the department staff is not present, the lead surveyor must contact the survey organization.

Facility Survey Scheduling

The survey organization defines its process for scheduling designation surveys. Surveyors cannot review a facility in their 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 four years. In addition, a surveyor cannot survey a facility for which they have had a business relationship within the past four years, including previous employment, previous contract relationships, or completion of a residency program. If you believe there is a potential for a conflict of interest, you 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 a survey of a facility with anyone other than the facility, survey team, survey organization's survey performance improvement process, or the department once you have completed the survey.
2. Avoid discussing or sharing the name or referring to other hospitals you have surveyed in response to questions.

3. Always ask clarifying questions to statements and physically review data or documents; do not make assumptions about processes or hospital 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 review. Please ask these questions while you are reviewing the record. These questions are directed to the assigned navigator, medical director, or program manager.
5. Avoid making unnecessary comments, rendering personal opinions, or statements of "this is how we do it."
6. Clarify the facility's management guideline and the date it was 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, medical director, or program manager to clarify at that time. Provide the facility an opportunity to address concerns.
7. Manage your time to ensure you can successfully complete a minimum of ten 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/QAPI 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/QAPI 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/QAPI 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 secondary level of review, date of the tertiary level 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/QAPI. This includes identifying any facility or equipment issues that are outdated or do not meet the designation requirements.

12. 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 that 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.

Facility Validation Expectations

1. The medical record reviews reflect care that aligns with the facility's documented management guidelines that align with the national standards of care.
2. Documentation is systematic and includes the timely evaluation and assessment of the patient, diagnostic evaluations, consultants requested, interventions, procedures, response times, patient outcomes, ongoing assessments, consultation resources, psychological support, and discharge planning process.
3. PIPS/QAPI plan identifies variances in clinical care, the management guidelines or system response, defines the level of harm and level of review, opportunities for improvement, and works through the defined action plan to produce change at the patient's bedside or system that is validated by data.
4. Current policies, procedures, protocols, and evidence-based practice or management guidelines are implemented and monitored through the PIPS/QAPI process.
5. Documentation of education and training of staff and medical staff providing care to the patient population across the continuum of care and phases of care meet the designation requirements at a minimum.
6. The facility's program oversight and committees appropriately address system and patient care issues.
7. Documentation of case review meeting minutes identifies why the case was reviewed, opportunities for improvement (OFI), and discussion of recommendations. When OFIs are identified, the PIPS/QAPI tracks the corrective actions using data until the needed change occurs and is sustained for event resolution.

8. Interviews with staff reflect engagement with the program and that designation requirements are met.
9. Documentation reflects the registry or data management process is current, timely, and reliable. A data validation process to ensure accurate, complete data is effective. (This is specific to the trauma registry.)
10. Specific to trauma facility designations, injury severity scoring is accurate, and there is evidence of quarterly registry submission to the state trauma registry. If variances in data, data completion, access to data, or data accuracy are identified, ask the facility for their documentation improvement plan.

Pre-Survey Conference Call

The surveyors are expected to review the designation assessment questionnaire (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 surveyors 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 notes, 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 also allow a variety of medical record selections. It is important to note that 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. 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/QAPI 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 five days prior to the review. 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 surveyors and facility staff
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 performance improvement/quality assessment performance improvement plan
6. Review the program's performance dashboard
7. Review the disaster preparedness and planning activities
8. Provide an overview of the facility, demonstrating key areas involved in the designation 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 this determination during the pre-survey conference call with the facility. The surveyors will view the virtual tour provided and ask questions specific to their assigned areas. Surveyors need to be prepared with their questions. Questions need to be specific to the level of designation and designation requirements.

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

These 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 and volume, as evidenced in the questionnaire. 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 designation program. Each surveyor must complete ten medical record reviews and complete a medical record review summary tool for each record reviewed. Surveyors will review the designated program's PIPS/QAPI 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, the continuum of care through to discharge or transfer, patient handoff, communication, documentation, and the 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 performance improvement/quality assessment performance improvement 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 action plans, and the processes to achieve event resolution as defined in the designated program's implemented PIPS/QAPI Plan.

PIPS/QAPI Elements of Review

1. Event identification and date of identification
2. Impact of the event – Level of Harm
3. Levels of review – level, date of review, review included in associated program committee or oversight minutes
4. Committee case discussions and minutes
5. Defined opportunities for improvement
6. PIPS/QAPI Corrective Actions
7. Monitoring of the action plan
8. Event resolution

In all cases of death (including patients who made DNR while in the hospital or comfort care) and all cases with an identified moderate level of harm or higher or near-miss events with the potential for a moderate level of harm, the surveyor must review the PIPS/QAPI processes, action plan, associated minutes, opportunity for improvement, action plan, and data utilized to determine event resolution. It is important to note that these reviews can

never have a punitive or judgmental tone. The review must be objective, review facts, 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 and when the telemedicine service responded, the documentation of the telemedicine service, and if the documented management guidelines were followed. The surveyor should note in the medical record summary when telemedicine services are utilized, their response times, and if appropriate documentation is appropriate.

In addition, after each phase of care, the surveyor will define if the facility management guidelines were followed, if resources were appropriate, if coordination and continuum of care were appropriate, if documentation was appropriate, and if the oversight of the designation program was appropriate.

The surveyor is responsible for ensuring 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 leads to 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 findings and any additional information if required. If the surveyor asks for additional documents from the program staff, the surveyor needs to complete the review of those requested documents. If the surveyors identify a designation program best practice model, this should be included in the exit conference summary.

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

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

The lead surveyor will assign elements of the agenda for the exit conference 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.

Exit Conference

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

1. Reading the survey validation statement – lead surveyor
2. Requirements not met – lead surveyor
3. Opportunities for improvement – surveyor
4. Strengths of the program – surveyor
5. Best practices – surveyor
6. Regional integration and participation – surveyor
7. Recommendations and summary comments - lead surveyor
8. Next steps – DSHS Designation Coordinator or lead surveyor

Examples of Lead in Summary Comments

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

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

Survey Validation Statement

The lead surveyor will read the following statement:

The survey team members have completed your designation survey. Based on our review, we will share our survey findings beginning with the potential requirements not met, opportunities for improvement, strengths of the program, best practices identified, and regional integration and participation.

We will provide you with our recommendations to improve or further develop your program.

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 a designation survey summary report and forward the report and all medical record reviews to the facility's 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.

Survey Report

The surveyor will complete their sections of the survey 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 designation application once it is received and the application is complete. The department will review the designation survey summary report, all medical record review summaries, and the facility's submitted plan of correction(s) for designation requirements not met to determine the designation status. The goal is to complete the facility application review and process the designation application within 30 days of receiving a complete application. The department may schedule follow-up calls with the facility to review a corrective action plan or follow-up plan as necessary or to address other issues related to the survey summary report or site survey.

The department reviews survey reports and medical record summaries to validate all requirements are met. If all requirements are met, the department will email the designation award letter and certificate to the hospital CEO, program medical director, and program manager. The

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

Designation Survey Corrective Action Plans

It is important to know that the department reviews the designation summary report, the medical record summaries, and the facility's action plan in detail. This review will define if requirements are not met. If one to three requirements are not met, the department will call the facility to discuss the survey summary report findings and the identified requirements not met. The department will define a corrective action plan with the facility. In some situations, the facility's action plan will address the requirement not met, and this is removed from the list.

The requirements not met that remain may require the facility to send in specific reports, or they may require a focused review within 12 to 18 months from the original survey date. In this case, the facility will receive a contingent designation.

The focused review priorities are to specifically review the requirements not met during the site survey. The focused review may be completed by a member of the original survey team, a new surveyor, or a department designation coordinator. A focused review is a one-day survey that typically requires one surveyor, but in some cases, two surveyors may be required. The focused survey may be onsite or virtual.

If the facility has four or more designation requirements not met reported, the department reviews the survey report, medical record summaries, and the action plan submitted by the facility to clarify the requirements are not met. The department will call the facility and schedule a conference call with their program leaders and administrative staff to define the status of the action plans and review the requirements not met. The call discusses options for the corrective action plan.

If the call validates that four or more requirements are not met, the facility will receive a contingent probationary designation. This requires the facility to repeat the full designation survey with a new survey team within 12 to 18 months from the original survey date. The hospital will request a site survey through a department-approved survey organization and repeat the process of submitting the survey summary report and medical record reviews to the department for review. The survey summary report must define that all designation requirements are met to remove the 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 revoked, its designation level downgraded, or its designation suspended until all designation requirements are met.

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.

The department will prepare the facility's survey application, which includes the designation survey summary report, medical record review summaries, and the facility's action plan for the appeal review. The department blinds the documents and prepares the documents for the appeal process.

Maternal and Neonatal facilities will have a three-person Designation Appeal Panel review the blinded documents and make a recommendation regarding the designation level to the department. The Designation Appeal Panel meetings are closed and confidential. If the recommendation is to designate the facility at the same level defined by the department, the department will notify the facility. If the appeal panel recommends a change in the designation level awarded by the department, the department will review the recommendations and survey application again. The department will determine the level of designation and notify the facility. If the facility requests a second 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 Associate Commissioner. The Associate Commissioner reviews the appeal request and the facility's designation survey application and defines the designation level for the facility. Maternal and Neonatal facilities can request a hearing in accordance with the department's rules for contested cases and **Texas Government Code, Chapter 2001**.

Trauma facilities who 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.

The department will prepare the facility's survey application, which includes the designation survey summary report, medical record review summaries, and the facility's action plan for the appeal review. The department blinds the documents and prepares the documents for the appeal process.

The Trauma Designation Review Committee will review the blinded documents and make a recommendation regarding the designation level to the department. The Trauma Designation Review Committee meetings are closed and confidential. If the recommendation is to designate the facility at the same level defined by the department, the department will notify the facility. If the committee recommends a change in the designation level awarded by the department, the department will review the recommendations and survey application again. The department will determine the level of designation and notify the facility. 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 Associate Commissioner. The Associate 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**.

Stroke facilities will request an appeal in writing. 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.

The department will prepare the facility's survey application, which includes the designation survey summary report, medical record review summaries, and the facility's action plan for the appeal review. The EMS-Trauma Systems Section Director will review the appeal and define if the original designation is upheld or changed. The department will notify the facility within 15 business days.

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 Associate Commissioner. The Associate Commissioner reviews the appeal request and the facility's designation survey application and defines the

designation level for the facility. If the facility disagrees with the second level of appeal, the facility can request a hearing in accordance with the department's rules for contested cases and **Texas Government Code, Chapter 2001**.

Waivers and Exceptions to Designation Requirements

Designated facilities can request a waiver or an exception to a specific designation requirement they are not able to meet. The facility must submit a written, electronic request for the waiver or exception to the EMS-Trauma Systems Section at DSHS.EMS-TRAUMA@dshs.texas.gov. Facilities must have evidence that all other requirements are met and submit a documented plan of correction with a timeline to address the requirement they are not able to meet that is accepted by the department. The facility will work with the department to track the progress of the corrective actions. Facilities may refer to the specific designation rule for further information.

- Maternal and Neonatal waivers and exception requests are reviewed by the Designation Appeal Panel.
- Trauma waivers and exception requests are reviewed by the Trauma Designation Review Committee.
- Stroke waivers and exception requests are reviewed by the department.

DESIGNATION SURVEY GUIDELINES SUMMARY

These designation survey guidelines define the processes and expectations for the 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.

Timeline for Implementation of These Designation Survey Guidelines

- These survey guidelines will be shared on the department website in July. The department will review the guidelines with stakeholders beginning in August of 2023. Education specific to the guidelines will begin in August of 2023.
- Applications to be recognized as a department-approved survey organization will be opened on September 1, 2023, and must be received by December 1, 2023.
- The designation survey guidelines will be implemented in all types and levels of designation surveys beginning January 1, 2024.

Questions regarding the designation survey guidelines are directed to the department at **DSHS.EMS-TRAUMA@dshs.texas.gov**.

EMS TRAUMA SYSTEMS DESIGNATION UNIT

Website Information

Texas Department of State Health Services

EMS Trauma Systems

Programs

Maternal Designation

Neonatal Designation

Stroke Designation

Trauma Designation

Designation Unit Email Address:

DSHS.EMS-TRAUMA@dshs.texas.gov

Staff Contact Information

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

Trauma

American College of Surgeons (ACS)

- Website for General Information:
  Trauma | ACS (facs.org)
- Website to 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), and Advanced (Level III)

Texas EMS Trauma & Acute Care Foundation (TETAF)

- Website for General Trauma Survey Information:
  Trauma Survey Services - TETAF
- Website to 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) and Basic (Level IV)

APPENDIX B: COMMON SCREENING EVENTS/PIPS/ QAPI EVENT

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. If an event is identified, the impact of the event or level of harm is defined and documented. The event documentation is processed 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 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 hospital's mass casualty planning and preparedness	X	X	X	X
Evidence the facility has implemented measures to foster a safe culture	X	X	X	X
Evidence the facility has implemented trauma-informed care practices	X	X	X	X
Evidence the facility has measures to validate physician requirements for trauma designation are met	X	X	X	X
Registry data is submitted to the state registry quarterly	X	X	X	X
Evidence that registry data is validated and includes the patient's ISS score	X	X	X	X
Diversion time is monitored and reviewed to define the reason for diversion and trends with corrective action plans	X	X	X	X
Compliance with trauma team activation guidelines. Variances are defined as delayed activations or missed activations	X	X	X	X
Surgeon arrival time per trauma activation guidelines is monitored	X	X	X	X
Compliance with resuscitation guidelines is monitored	X	X	X	X
Compliance with serial vital signs, GCS and RTS assessments and reassessments is monitored	X	X	X	X
Delay in response for urgent (30-minute response) assessment by the neurosurgery and orthopaedic specialists	X	X	X	X

Delay in recognition of injury or missed injuries	X	X	X	X
Compliance with prehospital triage criteria as determined by regional protocols	X	X	X	X
Over and under triage are monitored and reported quarterly	X	X	X	X
Required Screening Events for Trauma PIPS	**Level I**	**Level II**	**Level III**	**Level IV**
Delays in care due to the unavailability of Emergency Department physician (Level III and IV)	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
Compliance with DVT prophylaxis guidelines	X			
Unanticipated return to the operating room or unanticipated operative intervention	X	X	X	X
Unanticipated transfer to the Intensive Care Unit (ICU) or intermediate care	X	X	X	X
Transfers out of the facility are monitored for timeliness of decision to transfer, transportation availability, and receiving facility feedback	X	X	X	X
Transfers from inpatient unit to another facility for definitive care reviewed through the secondary and tertiary levels of review	X	X	X	X
Abuse screening is completed and documented	X	X	X	X
Patients who meet trauma activation criteria with a projected ISS score of 11, and the evaluating physician's decision is to transfer the patient, but the patient is not transferred to a higher-level trauma center	X	X	X	X
All identified opportunities for regional improvement are referred to the local regional trauma advisory council	X	X	X	X
All Non-Surgical Admissions for patients meeting trauma activation guidelines are reviewed through the secondary level of review and potentially tertiary level of review	X	X	X	X
Radiology discrepancies between the preliminary and final reports that create a change in the plan of care	X	X	X	X
Delays in access to time-sensitive diagnostic or therapeutic interventions are identified and reviewed through the PIPS process	X	X	X	X
Compliance with guidelines related to timely access to the operating room for urgent surgical intervention (greater than a 30-minute response time to open an OR)	X	X	X	X
Delays in physician response to the ICU for patients with critical needs are monitored through the secondary level of review at a minimum	X	X	X	X
Lack of essential equipment for resuscitation, patient monitoring, interventions, and inpatient care for all patient populations	X	X	X	X

Massive transfusion protocol activations that have incorrect products or ratios, a delay in arriving at the patient's bedside, or blood wastage	X	X	X	X
Complications and adverse events are reviewed at the trauma PIPS process	X	X	X	X
Transfers to hospice	X	X	X	X
Required Screening Events for Trauma PIPS	**Level I**	**Level II**	**Level III**	**Level IV**
All Deaths (DOAs, DIED, inpatients deaths, patients made DNR after admission for injury, or decisions for comfort care after admission for injury)	X	X	X	X
Patient referral and organ procurement rates	X	X	X	X
Screening of eligible patients for psychological sequelae	X	X	X	X
Delays in providing rehab services (OT, PT, Speech)	X	X	X	X
Screening of eligible patients for substance use, misuse, and mental health screening, and if screening is positive, intervention provided	X	X	X	X
Variances in following the trauma management guidelines or best practice guidelines	X	X	X	X
Variances in backup call schedule or contingency plan	X	X	X	X
Telemedicine utilization without video capabilities	X	X	X	X
Telemedicine without appropriate documentation	X	X	X	X
Telemedicine failure to participate in performance improvement process	X	X	X	X
Trauma billing practices and utilization of uncompensated trauma funding to advance the facility's trauma program are shared with the trauma operations committee	X	X	X	X
Failure to document and include the wristband number in the registry and electronic medical record	X	X	X	X
Operations committee meeting attendance does not meet standards	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	X	X	X	X
Failure to maintain compliance with educational and certification requirements	X	X	X	X
Failure to have two RNs at the highest level of trauma activation resuscitations	X	X	X	X
Failure to provide EMS or transferring facilities follow-up information on identified opportunities or as follow-up is requested	X	X	X	X
Facilities with 15% or more of their trauma activations and trauma admissions that are 65 years of age or older have written trauma geriatric management guidelines that are monitored	X	X	X	X

Missed recognition or treatment of shock, defined as a systolic BP of 110 or less, in the geriatric (65 or older) population	X	X	X	X
Facilities with 15% or more of their trauma activations and trauma admissions that are less than 15 years of age have written trauma pediatric management guidelines that are monitored	X	X	X	X
Required Screening Events for Trauma PIPS	**Level I**	**Level II**	**Level III**	**Level IV**
All trauma 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 quarterly, 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.)	X	X	X	X
Pediatric weights are documented in kg	X	X	X	X
Pediatric full vital signs (T; HR; R: BP), including pain assessment, are documented	X	X	X	X
Pediatric initial and serial GCS and RTS are documented for patients with shock, potential TBI, or multisystem injuries	X	X	X	X
Pediatric serial vital signs are documented	X	X	X	X
Pediatric equipment is available for resuscitation in diagnostic areas, OR, and inpatient settings	X	X	X	X
Facility has management guidelines for pediatric imaging and initial resuscitation, which are monitored	X	X	X	X
Pediatric abuse screening is completed and documented	X	X	X	X
Pediatric psychosocial support services are available	X	X	X	X

APPENDIX C: 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

RULE §157.125 Program Requirements

(a)(1) Comprehensive (Level I) trauma facility designation – The facility, including a free-standing children's facility, meets the current American College of Surgeons (ACS) essential criteria for a verified Level I trauma center; meets the "Advanced Trauma Facility Criteria" in subsection (x) of this section; actively participates on the appropriate Regional Advisory Council (RAC); has appropriates services for dealing with stressful events available to emergency/trauma care providers; and submits data to the Texas EMS/Trauma.

(a)(2) Major (Level II) trauma facility designation – The facility, including a free-standing children's facility, meets the current ACS essential criteria for a verified Level II trauma center; meets the "Advanced Trauma Facility Criteria" in subsection (x) of this section; actively participates on the appropriate RAC; has appropriates services for dealing with

stressful events available to emergency/trauma care providers; and submits data to the Texas EMS/Trauma.

(a)(3) Advanced (Level III) trauma facility designation – The facility meets the "Advanced Trauma Facility Criteria" in subsection (x) of this section; actively participates in the appropriate RAC; has appropriate services for dealing with stressful events available to emergency/trauma care providers; and submits data to the Texas EMS/Trauma.

(a)(4) Basic (Level IV) trauma facility designation – The facility meets the "Basic Trauma Facility Criteria" in subsection (y) of this section; actively participates in the appropriate RAC; has appropriate services for dealing with stressful events available to emergency/trauma care providers; and submits data to the Texas EMS/Trauma.

(x)(G)(7) Trauma registry – data shall be forwarded to the state trauma registry on at least a quarterly basis.

(y)(G)(6) Trauma registry – data shall be forwarded to the state trauma registry on at least a quarterly basis.

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 two 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 ten trauma-related research articles*
2. Participation by at least one 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)

TAC 157.125 Requirements

157.125(x) Advanced (Level III) Trauma Facility

157.125(x)(J) Outreach Program

1. Provide education to and consultations with physicians of the community and outlying areas.
2. A defined individual to coordinate the facility's community outreach programs for the public and professionals is evident.

157.125(x)(K) Public Education/Injury Prevention.

1. A public education program to address the major injury problems within the hospital's service area. Documented participation in a RAC injury prevention program is acceptable.
2. Coordinator and/or participation in community/RAC injury prevention activities.

157.125(x)(M) Research. Trauma registry performance improvement activities.

157.125(y) Basic (Level IV) Trauma Facility

157.125(y)(J) Public Education/Injury Prevention

1. A public education program to address the major injury problems within the hospital's service area. Documented participation in a RAC injury prevention program is acceptable.
2. Coordinator and/or participation in community/RAC injury prevention activities.

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

(To be completed on every chart selected)

Patient Injury Diagnosis	Last Name:		
	Age/Gender	Mechanism of Injury	
MRN/Trauma Registry #			
Injury Category			
ISS			
EMS Scene Time / Summary			
Trauma Team Activation	Yes ☐ No ☐ Level: _____ Timely Activation ☐ Delayed Activation ☐ Missed Activation ☐		
Patient Arrival at Trauma Resuscitation Bay/ED	Date:	Time:	Surgeon/Physician Arrival Time:
Time of Initial Imaging	Chest Xray	Pelvic Xray	CT
MTP Activated	Yes ☐ No ☐ If yes, time requested: _____ Time of first unit:_____		
Consultant Services engaged in resuscitation/evaluation			
Response time for services meeting the 30-minute response requirement	Neuro	Ortho	IR

Patient ED Disposition	OR ☐ Floor ☐ ICU ☐ IR ☐ Transfer ☐		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 three 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 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 the Medical Record Face Sheets for the trauma medical records 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, 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 and
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 on-site, 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 surveys as specified by the department.

Each surveyor is required to review ten medical records. The number of medical records prepared is based on the following:

- Adult Program Level I or II: 50 medical records
- Pediatric Program Level I or II: 50 medical records
- Combined Adult and Pediatric Programs:
    - Adult Level I or II and Pediatric Level II: 75 medical records (50 adult medical records and 25 pediatric medical records)
    - Adult Level I and Pediatric Level I: 90 medical records
      (45 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
    - 45 medical records for four surveyors
- Level IV Program:
    - 15 medical records for one surveyor
    - 25 medical records for two surveyors
    - 35 medical records for three surveyors
    - 45 medical records for four 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 focused reviews, medical records and PIPS documentation must be selected for the identified requirements not met during the initial survey. The department may define specific requirements for the focused review.

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 electronically, even in the virtual surveys. The program makes this decision and not the survey organization. This prevents the unnecessary burden of the program printing out all medical record documents.

If a virtual electronic medical record 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 products – 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, Box, Sharepoint, Sharefile, or any system approved by the hospital's compliance/Information Technology (IT) department).
5. Provided to the survey team as early as your 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:

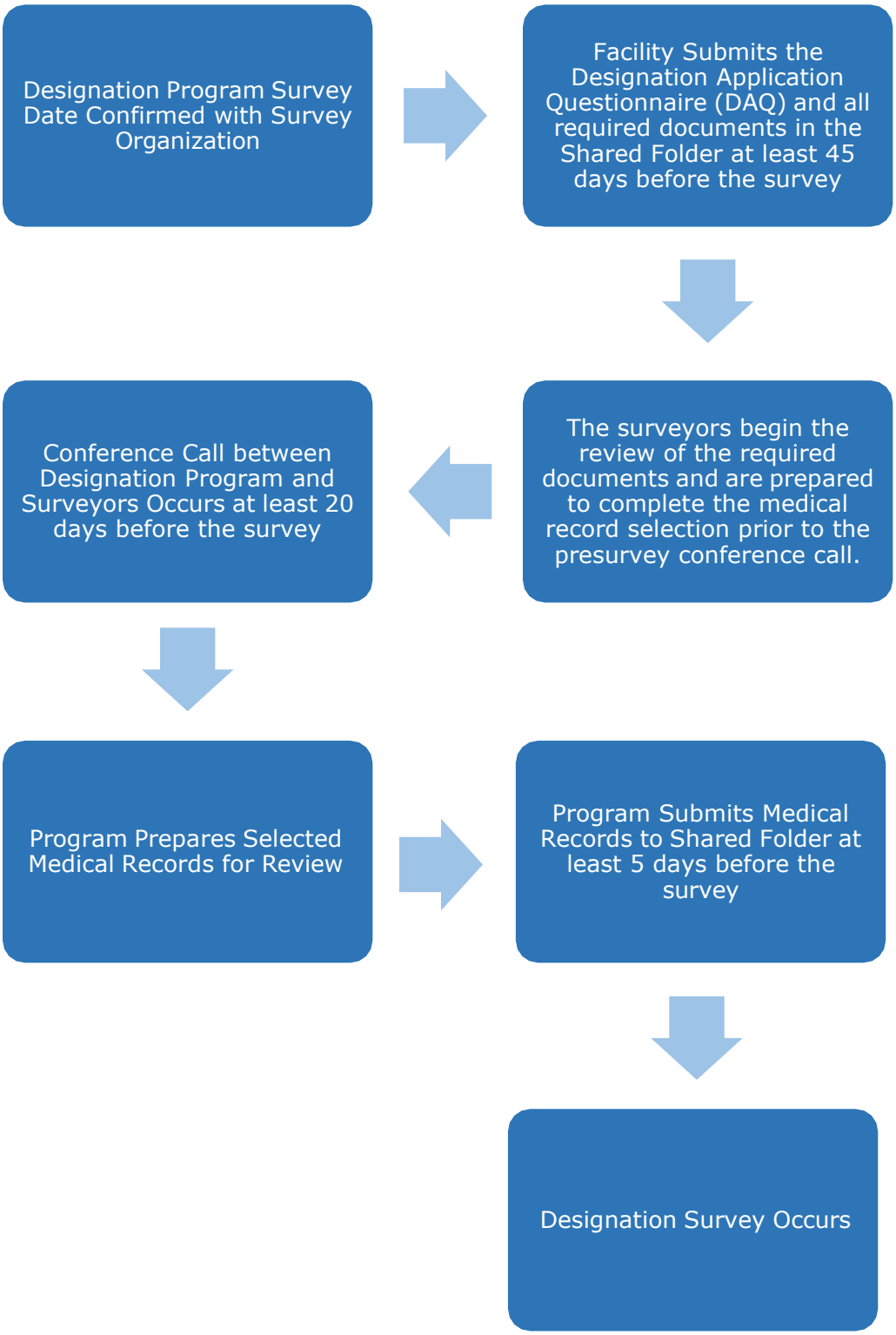
1. Trauma Medical Record Face Sheet
2. PIPS documentation to include:
    a. Event identification and date
    b. Level of harm
    c. Primary level of review
    d. Secondary level of review
    e. Tertiary level of review
    f. Minutes of case discussions to include data and attendance
    g. Opportunities 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), all supporting information, with this 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 Emergency Department (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)
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	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 operating room	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 neurovascular 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
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 operating room	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
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 will choose medical records based on their volume and services provided.

Medical Record Planning Submission Timeline



Designation Survey Team Composition

Designation Program Surveyors	Level I	Level II	Level III	Level IV
Trauma Designation				
Level IV				
Trauma Registered Nurse (1)				X
Additional Surveyor – Surgeon (1) if trauma surgery is performed in the facility				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 7/31/2023 , 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

Application Details

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 effective January 1, 2024, will be opened September 1, 2023. The application must be submitted to the department prior to December 1, 2023.

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

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

Complete an application for each designation program requested.

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 effective January 1, 2024, will be opened September 1, 2023. The application must be submitted to the department prior to October 31st, 2023.

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 1st and January 31st 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 performance improvement / quality assessment performance improvement course 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

Trauma

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 neonatal 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. Can EMS activate the trauma team from the field?
3. Discuss the hospital'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 does the facility provide feedback to the EMS personnel regarding a patient transported to the facility?
12. Describe how the trauma team is activated.
13. Who can activate the trauma team?
14. Who are the members of the trauma team?
15. Define the staffing pattern for the highest level of activation.
16. What is the role of non-clinical trauma team members, if applicable?
17. How are ED clinical and ancillary staff educated and trained on the activation criteria, the activation process, and their roles and responsibilities?
18. How are the activation response times recorded and monitored?
19. Define how staff are educated and trained regarding their role in the trauma care management guidelines and documentation requirements.
20. How are ED staff educated and trained to manage trauma patients?
21. What competencies and certifications are required for the ED staff?
22. Is there a designated area or room for the treatment of the trauma patient?
23. Who oversees the trauma resuscitation?
24. Who is responsible for the patient's airway management?

Respiratory Therapy (RT)

1. Describe the role in intubation and vent management.
2. Is end-tidal CO_2 monitoring available in the resuscitation room?
3. Are there protocols that define the criteria for utilizing end-tidal CO_2 monitoring?
4. If not, how is airway patency monitored?

ED Clinical Staff/Leadership

1. Is the Focused Assessment with Sonography in Trauma (FAST) exam utilized?
2. If yes, who is credentialled to complete a FAST exam?
3. How is this monitored through the trauma performance improvement and patient safety (PIPS) process?
4. How are identified opportunities addressed?
5. Where are the care management guidelines located?
6. Are pediatric care management guidelines available?
7. Describe how pediatric trauma resuscitations are managed (if not a pediatric facility).
8. Did the facility complete a pediatric readiness survey this year?
9. If yes, what opportunities for improvement were identified?
10. How are the opportunities being addressed and status?
11. Are care management guidelines for geriatric trauma available?
12. If yes, how are staff educated and trained on these guidelines?
13. How are these guidelines (pediatric and geriatric) incorporated into the trauma PIPS process?
14. 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. Do blood bank personnel respond to trauma team activation?
2. If so, how is this monitored?
3. If not, what is their expected response time after STAT request for Massive Transfusion Protocol (MTP), and how is this monitored?
4. Is whole blood available?
5. What is the MTP transfusion ratio?
6. Who monitors blood wastage?

ED Clinical Staff/Leadership

1. Who is responsible for documenting the injuries and completing the trauma History

and Physical exam?
2. What barriers have been identified in expediting the admission/transfer of the trauma patient from the ED?
3. What plans are in place to address these barriers?
4. How are staff educated and trained regarding Trauma-Informed Care?
5. Describe how family care is provided.
6. How often are disaster drills held?
7. Describe the last disaster drill.
8. What was the scenario?
9. What lessons were learned?
10. Is training on roles and responsibilities during a disaster provided?

Transfer Center Staff

1. Describe how trauma transfers are initiated or accepted.
2. What is the process of providing feedback to the transferring facility?
3. How does the facility provide feedback to the EMS personnel regarding a patient transported to the facility?
4. How are images shared between transferring and receiving facilities?
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?

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 twenty-four 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. Describe how call-back times are monitored and reported.
2. What are the turn-around times for radiologist imaging interpretations, and how is this monitored?
3. Is this data presented to the Trauma Operations Committee?
4. Is radiology notified when the trauma team is activated?

5. If so, how?
6. Does a staff member respond?
7. What are the expected response times, and how is this monitored?
8. If a radiology overread identifies deviation from the original read, how is this managed and monitored?
9. 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. Describe the transport process of a trauma patient to IR.
4. Who monitors the patient while in IR?
5. Is there equipment for emergent resuscitation?
6. If IR staff is on-call, what is the expected response time, and how is this monitored?
7. Is this data presented to the Trauma Operations Committee?
8. Does Radiology provide data to the trauma PIPS?
9. How does Radiology participate in the PIPS process and the Trauma Operations Committee?
10. 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 procedure to secure uncrossed-matched O-negative blood for critical trauma patients in the resuscitation area?
2. Would whole blood be used instead of packed red blood cells?
3. Do you have a protocol for whole blood usage that defines which patients should receive whole blood?
4. What is the turnaround time for uncrossed-matched blood for the ED, OR, and ICU?
5. What is your relationship with the blood centers in the event you need blood products?
6. Who developed the MTP?
7. Who can initiate an MTP?
8. Do you have a policy with clearly defined criteria for initiating an MTP?
9. What are the processes for updating the protocol?
10. How is education provided to all areas regarding protocol updates?
11. How do the surgeon, pathologist, and anesthesia providers coordinate the needs of the bleeding trauma patient in the OR? Is there a written guideline?
12. How does this process change in a mass casualty event?
13. How are blood products managed in a mass casualty event??
14. How many simultaneous MTPs can your staff manage during a mass casualty event?
15. What data does the Blood Bank provide to the PIPS process?
16. How does the Blood Bank participate in the trauma PIPS process and Trauma Operations Committee?
17. 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 does the process change for a case at night or on a weekend?
3. What is the process for prioritizing multiple patients needing an operating room?
4. How is surgeon availability monitored?
5. What are the expected surgeon response times, and how are these monitored?
6. How is the on-call schedule for anesthesia monitored?
7. Where is the schedule located?
8. What are the expected anesthesia response times, and how are these monitored?
9. Are Certified Registered Nurse Anesthetists (CRNAs) utilized for coverage?
10. If yes, define this process and supervision requirements.
11. How are the operating room staff educated and trained to manage trauma operative interventions?
12. What competencies and certifications are required for the OR staff?
13. Do the OR nurses have access to continuing education and conference attendance?
14. Who are the members of the OR team that provide care to critical stroke patients?
15. Is video monitoring available in the OR suite?
16. Is there a dedicated orthopedic operating room?
17. If not, describe the process in place that ensures orthopedics has a room available for any procedures necessary for extremity fracture management.
18. Are there dedicated orthopedic staff to support the orthopedic surgeons?
19. Is there a dedicated radiology technician for the OR?
20. Is there a C-Arm available?
21. Is there a dedicated neurosurgical OR?
22. Describe the equipment dedicated to that room.
23. Is there a policy in place that defines criteria for patient placement post-procedure?
24. Does the OR staff participate in disaster planning and preparedness? Describe what happens if the hospital is in a mass casualty situation and a stroke patient presents to the facility.
25. What is the hospital’s surge capacity preparedness?
26. Does Surgical Services provide data to the trauma PIPS?
27. How does Surgical Services participate in the PIPS process and the Trauma Operations Committee?
28. 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 stroke 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 a 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 stroke 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 the trauma program manager 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 (APP)
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 to 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 as 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 by a speeding pickup truck running a red light at the sedan's driver's side door. 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 80's year old female in the passenger side in the front seat. 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 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 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. How do the operating surgeon and the anesthesiologist communicate during a case to coordinate the patient's resuscitation?
25. Describe the decisions and guidelines in place to admit the trauma patient to the ICU versus the PACU.
26. What is the surgical coverage for the ICU?
27. What is the role of advanced practice providers in the ICU?
28. What are the ICU's capabilities and resources for managing a critical trauma patient? Orthopedic patient?
29. 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.

30. How is ventilator management in the ICU defined, and the relationship between the ICU service and the trauma service?
31. What clinical scenario requires the physical presence of the trauma-attending surgeon?
32. If a patient has an elevated ICP, who is notified?
33. What clinical scenario requires the physical presence of the neurosurgeon?
34. Who completes the tertiary exam?
35. Who manages the ICU multidisciplinary round? Who participates in these rounds? What lessons have been gained from these rounds?
36. How is wound care addressed in the ICU? Is there a wound service available?
37. Are bedside procedures performed in the ICU? If yes, can you describe the process?
38. If consulted in the ICU, when do rehabilitation services evaluate the patient?
39. Define the psychological support services available for the ICU patient. Family members?
40. Are there established ICU discharge criteria? How are these defined?
41. Is there a dedicated trauma unit? If yes, define the unit's capabilities and resources.
42. Is there a dedicated orthopedic unit? If yes, define the unit's capabilities and resources.
43. Is there a dedicated neurosurgical unit? If yes, define the unit's capabilities and resources.
44. Are advanced practice providers integrated with these teams or specific units? If yes, define their role.
45. 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?
46. What are the barriers to discharge planning?
47. Are there obstacles that impede the coordination of care?
48. 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
49. 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 PROCESS 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 Guidelines
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.								