Pre-Review Questionnaire
For
Kansas Level IV Trauma Center Designation

The Kansas Department of Health and Environment (KDHE), the Kansas Trauma Program (KTP), the Advisory Committee on Trauma (ACT), and the Regional Trauma Councils (RTCs) are pleased that your hospital wishes to participate in the statewide trauma system. In order to prepare for your onsite survey, please complete this Pre-Review Questionnaire (PRQ).

The PRQ allows site surveyors to have a preliminary understanding of the trauma care capabilities and performance of your hospital and medical staff before beginning the review. Please use the PRQ to gather your hospital's data. Please note, the site survey team may ask for further documentation to validate information on any question that is answered with a "yes."

Complete each section of the PRQ appropriate to your hospital's trauma care level. We ask that you do not use abbreviations, write legibly, and attach additional pages if necessary. Ensure all attachments are included and labeled appropriately. See "Pre-Review Questionnaire (PRQ) Guidance for Kansas Level IV Trauma Center Designation" for additional details and assistance in completing the PRQ. Two checklists have been provided at the end of the document to assist in compiling the PRQ. The first checklist is "Documentation List-PRQ", a list of supporting documents to attach to the PRQ. The second list is "Documentation List-Site Survey", a list of documents to have available for the site surveyors during the onsite review. The PRQ must be submitted no later than 30 days prior to the scheduled site visit. Keep a copy of your PRQ for reference during the site visit.

The information used to complete the site survey report will be considered in both the initial designation and redesignation determinations. The data submitted may be used for analysis by KDHE-KTP and will not be used for any purpose other than intended. The trauma registry reporting period is defined as six (6) months--preferably twelve (12) months--for initial designation review and twelve (12) months for redesignation. The

data cannot be earlier than fifteen (15) months prior to the date of application. There must be at least six (6) months of concurrent data in the state trauma registry and the trauma program must demonstrate that protocols/policies, performance improvement program/initiatives, timely registry submission, and injury prevention efforts have been in place and continuous for a minimum of six (6) months--preferably (12) twelve months-- prior to submission for initial designation. Ongoing data submission (quarterly) is a criterion for redesignation.

The PRQ can be submitted by paper or electronically. Note: if submitting electronically, include hospital name and date in the subject line and email to ren.morton@ks.gov. Alternatively, the PRQ can be mailed to:

Kansas Department of Health and Environment
Kansas Trauma Program
Attention: Wendy O'Hare
1000 SW Jackson, Suite 340
Topeka, KS 66612

Once the PRQ is received by the KTP, the trauma program nurse manager is listed on the PRQ will receive electronic confirmation of receipt.

Pre-Review Questionnaire

Please answer ALL questions completely. Do not use abbreviations.

Type of Site Visit

- ☐ Initial Designation Level IV Trauma Center
- ☐ Redesignation Level IV Trauma Center

Membership of Regional Trauma Council

- ☐ Northeast ☐ North Central ☐ Northwest
- ☐ Southeast ☐ South Central ☐ Southeast

Reporting time frame for this document

Six (6) months--preferably twelve (12) months--of data must be submitted into the state trauma registry prior to applying for designation as a level IV trauma center for the first time. The twelve (12) month time frame must start no earlier than fifteen (15) months from the date of application. Ongoing data submission (quarterly) is a requirement for redesignation. (See Appendix A: Kansas Trauma Registry Data Submission Due Dates)

Trauma Registry Data Reporting Date Range	Beginning Month _____ Year _____	Ending Month _____ Year _____
Primary Contact for Questionnaire		
Name	Position	Direct Phone Number ( )___ - ____ Email Address
Hospital Information		
Name of Hospital	Address	City, State, Zip Code
Main Phone Number ( )___ - ____	Emergency Department Phone Number ( )___ - ____	Patient Transfer Phone Number ( )___ - ____
Fax Number ( )___ - ____	Website Address	
Administrator/CEO Name	Administrator Direct Phone Number ( )___ - ____	Administrator/CEO Email Address
DON Name	DON Direct Phone Number ( )___ - ____	DON Email Address

Demographics		
Please provide population numbers of the community your hospital serves.	General population-number of catchment area Population _____	
Please provide total number of emergency department (ED) visits for reporting period.	Pediatrics (0-14 years old)	Adults (15 years and older)
Please provide the total number of trauma related emergency department (ED) visits for reporting period. (See Appendix B: Kansas Trauma Registry Inclusion Criteria)	Pediatrics (0-14 years old)	Adults (15 years and older)
Please provide the total number of trauma activations for the reporting period.	Pediatrics (0-14 years old)	Adults (15 years and older)
Please provide the total number of trauma patients transferred to a higher-level trauma center within the reporting period. Level I trauma center _____ Level II trauma center _____ Level III trauma center _____ Level IV trauma center _____ Pediatric Trauma Center _____ Burn Center _____ Please provide the total number of trauma patients transferred to a non-designated trauma center. _____		
Please provide total number of injured patients admitted for the reporting period.	Pediatrics (0-14 years old)	Adults (15 years and older)
Please provide the total number of trauma deaths for the reporting period.	Pediatrics (0-14 years old)	Adults (15 years and older)
Please provide the number of licensed hospital beds.		_____
Please provide the average daily census your hospital.		_____
Please provide the number of beds in the emergency department.		_____
Please provide the number of emergency department beds that are dedicated to trauma.		_____
Please provide the number of critical care beds (if applicable).		_____
Please provide the number of ICU beds (if applicable).		_____

Trauma Systems		
Hospital Commitment		
Is there a hospital resolution, signed within the past 6 months, supporting the trauma program from your hospital's governing board?	☐ Yes ☐ No	**Attachment #1** Hospital Resolution
Is there a medical staff resolution, signed within the past 6 months, supporting the trauma program?	☐ Yes ☐ No	**Attachment #2** Medical Staff Resolution
Is the trauma program identified on your hospital's organizational chart and is in a position to suggest/make changes within the hospital?	☐ Yes ☐ No	**Attachment #3** Hospital Organizational Chart
Is there a commitment by the hospital to have a practitioner (minimum an RN) present in the emergency department (ED) upon the arrival of patients meeting trauma team activation criteria? **Note: If "yes", please have the previous 3 months of emergency department staffing schedules available for review during onsite survey.**	☐ Yes ☐ No	**Supplement #1** ED staffing schedule (previous 3 months)
Is there specific budgetary support for the trauma program such as personnel, education, and equipment?	☐ Yes ☐ No	
If "yes" briefly describe.	Description	

Trauma Medical Director (TMD)		
Name/Credentials	Direct Phone Number ( )___ - ____	Email Address
Practice specialty of TMD?	List practice specialties	**Attachment #4** TMD Position Description
Advanced Trauma Life Support (ATLS) certified (current)?	☐ Yes ☐ No Date of expiration: Month ____ Year ____	**Attachment #5** TMD ATLS credential card
Is the TMD currently practicing?	☐ Yes ☐ No	
Has the TMD attended a Level IV Trauma Center Management & Organization Workshop?	☐ Yes ☐ No	

Trauma Program Manager/Coordinator (TPM)		
Name/Credentials	Direct Phone Number ( )___ - ____	Email Address

Is the TPM a fulltime position fully dedicated to trauma?	☐ Yes ☐ No If "no", how many hours is the position dedicated to trauma per week? Hours _____	**Attachment #6** TPM Position Description
Trauma Nursing Core Course (TNCC) certified (current)? Date of expiration: Month ____ Year ____	☐ Yes ☐ No	**Attachment #7** TPM TNCC credential card
Has the TPM completed a Trauma Program Manager Course or developed an action plan to complete a course?	☐ Yes ☐ No	**Attachment #8** TPM Trauma Program Manager Course Certificate of Completion or Completion Action Plan
Has the TPM attended a Level IV Trauma Center Management & Organization Workshop?	☐ Yes ☐ No	
Trauma Registrar *(if another staff member other than TPM)*		
Name	Direct Phone Number ( )___ - ____	Email Address
If the trauma registrar is another staff member other than the TPM, what department does the trauma registrar reside in? Name of Department _____		
Injury Prevention Coordinator *(if another staff member other than TPM)*		
Name	Direct Phone Number ( )___ - ____	Email Address
Staff Education Coordinator		
Name	Direct Phone Number ( )___ - ____	Email Address
Trauma Program		
Does your hospital have clinical practice guidelines, protocols, and algorithms derived from evidence-based validated resources or consensus-based validated resources or consensus-based institutional guidelines that have been established according to the most current peer-reviewed literature and clinical experience and acumen?	☐ Yes ☐ No	**Supplement #2** Clinical practice guidelines, protocols, and algorithms
Does your hospital have a trauma flow sheet?	☐ Yes ☐ No	**Attachment #9** Trauma Flow Sheet

Trauma System Planning		
Does your hospital's trauma program staff participate in state and/or regional trauma system planning, development, or operation?	☐ Yes ☐ No	**Attachment #10** Description of trauma system planning participation and/or activities log
Will your hospital participate in regional performance improvement meetings (if asked by regional trauma council leadership) as described in your region's *Regional Trauma Plan? ***The regional trauma plans can be found at www.kstrauma.org under the hospital's regional webpage.**	☐ Yes ☐ No	

Regional Trauma Council General Membership Members		
Hospital Administrator Representative Name	Direct Phone Number ( )___ - ____	Email Address
Hospital Nurse Representative Name	Direct Phone Number ( )___ - ____	Email Address
Hospital Physician Representative Name	Direct Phone Number ( )___ - ____	Email Address

Trauma Team Activation		
Trauma Team Activation (TTA)		
Does your hospital have a trauma team activation (TTA) policy that addresses the minimum requirements listed for highest level of activation?		**Attachment #11** TTA Policy
1. Confirmed blood pressure less than 90 mmHg at any time in adults and age-specific hypotension in children.	☐ Yes ☐ No	
2. Gunshot wounds to the neck, chest, or abdomen or extremities proximal to the elbow/knee.	☐ Yes ☐ No	
3. Glasgow Coma Score less than nine (9), with mechanism attributed to trauma.	☐ Yes ☐ No	
4. Transfer patients from other hospitals receiving blood to maintain vital signs.	☐ Yes ☐ No	
5. Intubated patients transferred from the scene	☐ Yes ☐ No	
6. Patients who have respiratory compromise or are in need of an emergent airway	☐ Yes ☐ No	
a. Includes intubated patients who are transferred from another facility with ongoing respiratory compromise (does not include patients intubated at another facility who are now stable from a respiratory standpoint)		
7. Emergency physician's discretion.	☐ Yes ☐ No	
How many levels of activation does your hospital's TTA policy have?	☐ 1 level ☐ 2 levels ☐ 3 levels	

How is your hospital's trauma team members notified for trauma team activation? *(Check all that apply)*	☐ Group Pager ☐ Telephone Page ☐ Overhead Paging System ☐ Other ______________________
Who in your hospital has the authority to initiate trauma team activation? *(Check all that apply)*	☐ Emergency Medical Services (EMS) ☐ Emergency Department (ED) Nurse ☐ Emergency Department (ED) Physician ☐ Emergency Department (ED) Midlevel ☐ Trauma Surgeon ☐ Other ______________________

Trauma Team Members

Please list all trauma team members by position and department associated with each level of trauma team activation.

		Activation Level			
Position	Department	Level I (Highest level)	Level 2 (Intermediate or lowest level)	Level 3 (Lowest level)	Response Time Requirement

Trauma Team Leader & Other Advanced Practitioners

Please list all trauma team leaders and advanced practitioners.

Name of Provider	Credential	Date of current board certification	Board Eligible? (if not board-certified)	Specialty Certification	ATLS Completion Date	% of attending Performance Improvement Meetings
	☐MD/DO ☐PA ☐NP		☐Yes ☐No			
	☐MD/DO ☐PA ☐NP		☐Yes ☐No			
	☐MD/DO ☐PA ☐NP		☐Yes ☐No			
	☐MD/DO ☐PA ☐NP		☐Yes ☐No			
	☐MD/DO ☐PA ☐NP		☐Yes ☐No			
	☐MD/DO ☐PA ☐NP		☐Yes ☐No			
	☐MD/DO ☐PA ☐NP		☐Yes ☐No			
	☐MD/DO ☐PA ☐NP		☐Yes ☐No			
	☐MD/DO ☐PA ☐NP		☐Yes ☐No			

Trauma Team Nurses		
Are all trauma team nurses certified in Trauma Nursing Core Course (TNCC)?	☐ Yes ☐ No	**Supplement #3** TNCC Compliance Report
If "no", does your hospital have a plan to ensure all trauma team nurses are TNCC?	☐ Yes ☐ No	**Supplement #4** TNCC Action Plan

On-Call Schedules	
Site surveyors will review all trauma team members' on-call schedules for the past three (3) months during the site visit.	**Supplement #5** Trauma team members on-call schedules (previous 3 months)

Transfer Plans		
Does your hospital have well-defined Trauma Transfer Plans?	☐ Yes ☐ No	**Supplement #6** Trauma Transfer Plans

Diversion		
Does your hospital have a written diversion plan?	☐ Yes ☐ No	**Supplement #7** Diversion Plan
Does your Diversion Plan include the following: Clearly define criteria for placing the trauma center on diversion status? Prearranged alternative destinations with transfer agreements in place? Does your hospital do the following when on Diversion: Notify other facilities (facilities, EMS, 911 dispatch, etc.) of divert status? Maintain a divert log? Review all diversions in performance improvement (PI) review?	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	

Has your hospital gone on trauma diversion within the reporting period?	☐ Yes ☐ No	
If "yes", briefly describe including diversion date, length of time, and reason for occurrence.	Description	
Prehospital Trauma Care		
Prehospital Trauma Care		
Describe the ground ambulance service in the area including type and location.	Description	
Describe the air transport services available in the area including the type and location.	Description	
Does your ground transport service (s) use field triage guidelines when determining the most appropriate destination for the injured patient? (See Appendix C-Guidelines for Field Triage of Injured Patients)	☐ Yes ☐ No	
If "yes", are field triage guidelines written in EMS protocols?	☐ Yes ☐ No	
Does your hospital have a dedicated helipad?	☐ Yes ☐ No	
If "no", briefly describe where the air ambulance lands?	Description	
Does your hospital serve as a base station for EMS operations?	☐ Yes ☐ No	
Does your hospital provide medical control?	☐ Yes ☐ No	
Is your hospital involved in pre-hospital (EMS) training? Note: EMS training could consist of case reviews/patient follow-up, hospital sponsored classes, and continuing education.	☐ Yes ☐ No	**Supplement #8** Documentation of prehospital training activities
If "yes", briefly describe.	Description	

Is your hospital involved in the development and improvement of prehospital care protocols?	☐ Yes ☐ No	**Supplement #9** Documentation of collaboration in prehospital protocol development
If "yes", briefly describe.	Description	
Is your hospital involved in performance improvement and patient safety (PIPS) activities with prehospital agencies?	☐ Yes ☐ No	**Supplement #10** Documentation of prehospital PIPS activities

Trauma Center Responsibilities		
Emergency Department Equipment *Site surveyors will verify presence of equipment during onsite visit.*		
Equipment	**Adult sized**	**Pediatric Sized**
Airway control and ventilation equipment including laryngoscopes and laryngoscope blades, ET tubes, oxygen and pocket mask	☐ Yes ☐ No	☐ Yes ☐ No
Pulse oximetry	☐ Yes ☐ No	☐ Yes ☐ No
Suction devices	☐ Yes ☐ No	☐ Yes ☐ No
Electrocardiography/oscilloscope/defibrillator	☐ Yes ☐ No	☐ Yes ☐ No
Standard IV fluids and administration sets	☐ Yes ☐ No	☐ Yes ☐ No
Large-bore intravenous catheters including I/O	☐ Yes ☐ No	☐ Yes ☐ No
Sterile surgical sets for: • Airway control/cricothyrotomy • Vascular access • Chest decompression/chest tubes	 ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	 ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
Gastric decompression	☐ Yes ☐ No	☐ Yes ☐ No
Drugs necessary for emergency care	☐ Yes ☐ No	☐ Yes ☐ No
Spinal immobilization equipment	☐ Yes ☐ No	☐ Yes ☐ No
Pediatric length-based resuscitation tape		☐ Yes ☐ No
Qualitative end-tidal CO2 detector	☐ Yes ☐ No	☐ Yes ☐ No
Thermal control equipment for patient	☐ Yes ☐ No	☐ Yes ☐ No
Equipment to facilitate communication with EMS	☐ Yes ☐ No	☐ Yes ☐ No

Transfer of Care within and Outside the Hospital		
Does your hospital have transfer agreements with: Higher level of care trauma centers? Pediatric trauma center(s)? Burn Center(s)? Other level IV trauma centers?	 ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	**Supplement #11** Trauma Transfer Agreements List trauma centers that your hospital has transfer agreements with: 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____
Does your hospital request and receive input or feedback from the receiving trauma center(s) that your hospital transfers patients to?	☐ Yes ☐ No	
If "yes", briefly describe.	Description	
Does your hospital perform performance improvement (PI) review include all inter-facility transfers?	☐ Yes ☐ No	
Brain Death Protocol		
Does your hospital have a written protocol for declaration of brain death (consider including Comfort Care Protocol for patients staying at your trauma center)?	☐ Yes ☐ No	**Attachment #12** Brain Death Protocol
Collaborative Services		
Radiology		
Is conventional radiography available 24-hours per day?	☐ Yes ☐ No	
Is computed tomography (CT) available 24-hours per day?	☐ Yes ☐ No	
Is there an in-house radiographer 24-hours per day?	☐ Yes ☐ No	
If "no", is there an on-call schedule for radiographers?	☐ Yes ☐ No	**Supplement #12** Radiographer's on-call schedule (previous 3 months)

Is the radiographer's response time monitored through the PIPS program?	☐ Yes ☐ No	**Supplement #13** Radiographer's response time PIPS documentation
What is the radiographer's response time requirement?	Response Time Requirement _____ minutes	
What is the radiographer's compliance percentage (%) for the reporting period?	Compliance percentage _____ %	
Is there a CT technician available in house 24/7?	☐ Yes ☐ No	
If "no", is there an on-call schedule for CT technicians?	☐ Yes ☐ No	**Supplement #14** CT technician's on-call schedule (previous 3 months)
Is the CT technician's response time monitored through the PIPS program?	☐ Yes ☐ No	**Supplement #15** CT technician's response time PIPS document
What is the CT technician's response time requirement?	Response Time Requirement _____ minutes	
What is the CT technician's compliance percentage (%) for the reporting period?	Compliance percentage _____ %	
Who provides F.A.S.T. for trauma patients? (Check all that apply)	☐ Radiology ☐ ED Physician ☐ Surgery ☐ None	
Is there a radiologist in-house 24/7?	☐ Yes ☐ No	
If "no", is there an on-call schedule for radiologists?	☐ Yes ☐ No	**Supplement #16** Radiologists on-call schedule (previous 3 months)
Is a radiologist promptly available, in person, when request for the interpretation of radiographs, performance of complex imaging studies, and interventional procedures?	☐ Yes ☐ No	**Supplement #17** Radiologist's response time PIPS documentation
Are radiologists promptly available, by teleradiology, when requested for interpretation of radiographs?	☐ Yes ☐ No	

If “yes”, what is the average turnaround time of interpretation of radiographs?	Average time _____ minutes	
Does your hospital have policies designed to ensure that trauma patients who may require resuscitation and monitoring are accompanied by appropriately trained providers during transportation to and while in the radiology department?	☐ Yes ☐ No	
Laboratory Services		
Does your hospital have 24-hour lab service?	☐ Yes ☐ No	
Does your hospital have a massive transfusion protocol or resuscitation protocol?	☐ Yes ☐ No	**Attachment #13** Massive Transfusion Protocol or Resuscitation Protocol
Does your hospital have uncrossed-matched blood immediately available?	☐ Yes ☐ No	
Is the blood bank capable of blood typing and cross matching? Note: Blood Bank is an optional criterion of Kansas Level IV Trauma Center Designation.	☐ Yes ☐ No	
What is the average turnaround times for:	Type specific blood _____ ☐ Not applicable Full cross-match _____ ☐ Not applicable	
Is there an on-call schedule for Laboratory personnel?	☐ Yes ☐ No	**Supplement #18** Laboratory personnel on-call schedule (previous 3 months)
Is Laboratory personnel response time monitored through the PIPS process?	☐ Yes ☐ No	**Supplement #19** Laboratory personnel response time PIPS documentation
What is the Laboratory personnel’s response time requirement?	Response Time Requirement _____ minutes	
What is the Laboratory personnel’s compliance percentage (%) for the reporting period?	Compliance percentage _____ %	

Performance Improvement & Patient Safety (PIPS)		
Performance Improvement & Patient Safety (PIPS)		
Does your hospital have a written PI plan that addresses the following criteria?		
Have an integrated, concurrent PIPS program to ensure optimal care and continuous improvement in care.		☐ Yes ☐ No
Describe the process for TMD and TPM to identify cases that should be referred for further information or peer review.		☐ Yes ☐ No
Once the event is identified, the trauma PIPS program must be able to verify and validate the event.		☐ Yes ☐ No
Require multidisciplinary physician involvement (when physicians of multiple disciplines are involved in trauma care).		☐ Yes ☐ No
Defined set of indicators/audit filter which must minimally include:	Emergency department provider non-compliance with on-call response times.	☐ Yes ☐ No
	Identification of training issues, including less than 100% of practitioners verified in ATLS or TNCC, as required.	☐ Yes ☐ No
	All TTAs.	☐ Yes ☐ No
	All trauma deaths.	☐ Yes ☐ No
	All trauma transfers in or out of the facility.	☐ Yes ☐ No
	Hospital specific filters to monitor areas that the trauma center believes it would benefit from surveying.	☐ Yes ☐ No
	Pediatric audit filters.	☐ Yes ☐ No
	Evaluation of transport activities.	☐ Yes ☐ No
All process and outcome measures must be documented within the trauma PIPS program and reviewed and updated at least annually.		☐ Yes ☐ No
Outline the process used to accomplish loop closure and resolution.		☐ Yes ☐ No
Identify routine timeframes for committee meeting that require the attendance of medical staff active in trauma resuscitation, to review systemic and care provider issues, as well as propose improvements to the care of the injured. This may be accomplished by assigning a physician liaison from involved departments.		☐ Yes ☐ No
For facilities with ICU capacity admitting patients to ICU level of care, documentation must demonstrate timely and appropriate ICU care and coverage are being provided.		☐ Yes ☐ No ☐ Not applicable

All trauma patients who are diverted or referred during the acute phase of hospitalization to another trauma center, acute care hospital, or specialty hospital or patient requiring cardiopulmonary bypass or when specialty personnel are unavailable must be subjected to individual case review to determine the rational for transfer, appropriateness of care, and opportunities for improvement. Follow-up with the center to which the patient was transferred should be obtained as part of the case review.	☐ Yes ☐ No
Affirm that the hospital will work with KDHE and the regional trauma council in statewide/regional PI activities.	☐ Yes ☐ No
Please attach the following:	**Attachment #14** PIPS Plan **Attachment #15** PIPS Attendance Policy
Please provide the following during onsite visit:	**Supplement #20** PIPS Committee Meeting Minutes (at least the last 6 months of committee meeting minutes) **Supplement #21** PIPS meeting dates **Supplement #22** PIPS member listing

Trauma Registry		
Trauma Registry		
Does your hospital have a process in place to validate/monitor cases that should be input into the trauma registry?	☐ Yes ☐ No	
If “yes”, briefly describe process.	Description	
Does your hospital have a process in place to validate the data that is input into the trauma registry?	☐ Yes ☐ No	
If “yes”, briefly describe process.	Description	
Does your hospital have appropriate measures in place to meet the confidentiality requirements of the data?	☐ Yes ☐ No	

Does your hospital use the Benchmark Data Report accessed through the trauma registry portal for PIPS?	☐ Yes ☐ No	**Attachment #16** Benchmark Data Report (most current)
Does your hospital use injury statistics available through the trauma registry for injury prevention planning?	☐ Yes ☐ No	
Prevention		
Universal Screening for Alcohol Use for Trauma Patients		
Does your hospital have a system (procedure) in place for ensuring universal screening for alcohol use on all patients that meet registry inclusion criteria with a hospital stay of > 24 hours and documentation of the screening?	☐ Yes ☐ No	**Supplement #23** Alcohol Screening for Trauma Patients Procedure
Which alcohol screening tool/resources does your hospital use?	Tool/Resource Name _____	
Injury Prevention		
Does your hospital have someone in a leadership position that has injury prevention as part of their job description?	☐ Yes ☐ No	**Attachment #17** Injury Prevention (leadership team member) Position Description
Does the hospital have an injury prevention program (s) based on local/regional trauma registry data?	☐ Yes ☐ No	**Attachment #18** Injury Prevention Initiatives/Activities
Disaster Planning and Management		
Does your hospital meet the disaster-related requirements of the Joint Commission?	☐ Yes ☐ No	
Does your hospital have a disaster plan described in the hospital's policy and procedure manual?	☐ Yes ☐ No	**Supplement # 24** Disaster Plan
How many times a year does your hospital test its disaster plan?	☐ 1 ☐ 2 ☐ 3 or more ☐ Not applicable	**Supplement # 25** Documentation of hospital disaster drills

Does your hospital participate in regional disaster management plans and exercises?	☐ Yes ☐ No	**Supplement # 26** Documentation of regional disaster management plans and exercises
If “yes”, briefly describe.	Description	

Renewal Application	
If initial application, skip this section	
Please provide the date of last site visit	Month ____ Day _____ Year ____
Please list any deficiencies cited at last survey and the corrective actions taken.	
Deficiencies	Corrective Action Taken

Please list any weaknesses found at last survey and actions taken to improve weaknesses.	
Weaknesses	Action Taken

Describe any program changes (administrative or staffing) that have occurred since the last survey.

Documentation Checklist
PRQ

Please attach the following documents to the PRQ (clearly label the attachments)

- ☐ Attachment #1 Hospital Resolution
- ☐ Attachment #2 Medical Staff Resolution
- ☐ Attachment #3 Hospital Organizational Chart
- ☐ Attachment #4 TMD Position Description
- ☐ Attachment #5 TMD ATLS credential card
- ☐ Attachment #6 TPM Position Description
- ☐ Attachment #7 TPM TNCC credential card
- ☐ Attachment #8 TPM-Trauma Program Manager Course Certificate of Completion or Completion Action Plan
- ☐ Attachment #9 Trauma Flow Sheet
- ☐ Attachment #10 Description of trauma system planning participation and/or activities log
- ☐ Attachment #11 TTA Policy
- ☐ Attachment #12 Brain Death Protocol (consider including Comfort Care Policy for those patients staying at your trauma center)
- ☐ Attachment #13 Massive Transfusion Protocol or Resuscitation Protocol
- ☐ Attachment #14 Performance Improvement and Patient Safety (PIPS) Plan
- ☐ Attachment #15 Performance Improvement and Patient Safety (PIPS) Attendance Policy
- ☐ Attachment #16 Benchmark Data Report (most current)
- ☐ Attachment #17 Injury Prevention (leadership team member) Position Description
- ☐ Attachment #18 Injury Prevention initiatives/activities

Documentation Checklist
Site Survey

Please have the following documents available at site survey (clearly label the supplements)

- ☐ Supplement #1 ED staffing schedule (previous three (3) months)
- ☐ Supplement #2 Clinical practice guidelines, protocols, and algorithms
- ☐ Supplement #3 TNCC Compliance Report
- ☐ Supplement #4 TNCC Action Plan
- ☐ Supplement #5 Trauma team members' on-call schedules (previous three (3) months)
- ☐ Supplement #6 Trauma Transfer Plans
- ☐ Supplement #7 Diversion Plan
- ☐ Supplement #8 Documentation of prehospital training activities
- ☐ Supplement #9 Documentation of collaboration in prehospital protocol development
- ☐ Supplement #10 Documentation of prehospital PIPS activities
- ☐ Supplement #11 Trauma Transfer Agreements
- ☐ Supplement #12 Radiographer's on-call schedule (previous three (3) months)
- ☐ Supplement #13 Radiographer's response time PIPS documentation
- ☐ Supplement #14 CT technician's on-call schedule (previous three (3) months)
- ☐ Supplement #15 CT technician's response time PIPS documentation
- ☐ Supplement #16 Radiologist's on-call schedule (previous three (3) months)
- ☐ Supplement #17 Radiologist response time PIPS documentation
- ☐ Supplement #18 Laboratory personnel on-call schedule (previous three (3) months)
- ☐ Supplement #19 Laboratory personnel response time PIPS documentation
- ☐ Supplement #20 PIPS Committee Meeting Minutes (at least the last six (6) months of committee meeting minutes)
- ☐ Supplement #21 PIPS Committee meeting dates
- ☐ Supplement #22 PIPS member listing
- ☐ Supplement #23 Alcohol Screening for Trauma Patients Procedure
- ☐ Supplement #24 Disaster Plan
- ☐ Supplement #25 Documentation of hospital disaster drills
- ☐ Supplement #26 Documentation of regional disaster management plans and exercises

Appendix A

Kansas Trauma Registry
Data Submission Due Dates

Discharged In	**Submission Due**
1st Quarter	May 31
2nd Quarter	August 31
3rd Quarter	November 30
4th Quarter	March 1

Quarters are Calendar Year Quarters:
1st Quarter includes discharges January 1 through March 31
2nd Quarter includes discharges April 1 through June 30
3rd Quarter includes discharges July 1 through September 30
4th Quarter includes discharges October 1 through December 31

Due dates are the same every year

Appendix B

Kansas Trauma Registry Inclusion Criteria

KANSAS TRAUMA PROGRAM — PLAN NOW. SAVE LIVES.

Revised October 2015

Registry Inclusion Criteria

Enter patients in the registry if they meet both the ***Diagnosis Criteria*** and ***Status Criteria.***
Do not enter patients meeting the *Exclusionary Diagnosis.*

Diagnosis Criteria:
To meet the diagnosis criteria, a patient must have **at least one** of the following ICD-10 diagnosis codes:

- **S00-99 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)*
- **T20-T28 with 7th character modifier of A ONLY** *(burns by specific body parts—initial encounter)*
- **T30-T32** *(burn by TBSA percentages)*
- **T79.A1—T79.A9 with 7th character modifier of A ONLY** *(Traumatic Compartment Syndrome—initial encounter)*

Status Criteria:
To meet status criteria, a patient must be:

- Transported from the scene by air ambulance or
- Pronounced dead in the Emergency Department regardless of whether the patient arrived with signs of life or had interventions performed, or
- Pronounced dead after receiving any evaluation or treatment during hospital admission, or
- Transferred to another acute care facility via EMS transport, or
- For adult patients (>14 years): Hospital length of stay for at least 48 hours, or observed for > 48 hours
- For pediatric patients (0-14 years): Any length of stay if admitted or observed

Exclusionary Diagnosis:

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

For questions related to software call:
Collector Technical Assistance (800) 344-3668 ext 4
For other questions call: Kansas Trauma Registry (785) 296-5459

Definitions

Admitted to the hospital: Patients should be formally admitted to the hospital as an in-patient or out-patient for acute or critical care to meet inclusion criteria. Patients admitted directly without an evaluation in the emergency department do meet inclusion criteria.

If a patient is kept under observation and subsequently admitted to the hospital, include the observation time in determining status criterion.

Readmission and Late Effects: Patients who are readmitted for the same injury or who seek care related to late effects or sequelae of a previous injury may not meet diagnostic criteria. Be careful to determine whether the diagnosis codes have been assigned appropriately. Late effects codes (7th digit modifiers of D through S) do not meet the diagnostic criteria.

GCS: Glasgow Coma Scale is the most widely used scoring system used in quantifying level of consciousness following traumatic brain injury.

Eye Opening	Spontaneous	4
	To Voice	3
	To Pain	2
	None	1
Verbal Response	Oriented	5
	Confused	4
	Inappropriate Words	3
	No words, only sounds	2
	None	1
Motor Response	Obeys commands	6
	Localizes pain	5
	Withdraws to pain	4
	Flexion to pain	3
	Extension to pain	2
	None	1
Total GCS = Eye + Verbal + Motor Scores		

Pronounced Dead in ED: These patients include those who were not pronounced dead at the injury scene, but while en route to your facility or at your facility. For example, if a patient is pronounced dead in the parking lot of the facility while being transported to your facility, this patient meets the ***Inclusion Criteria.***

Appendix C

Guidelines for Field Triage of Injured Patients