ACS Trauma Reverification Survey – October 2023

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Trauma Program Manager

John Muir Medical Center – Walnut Creek

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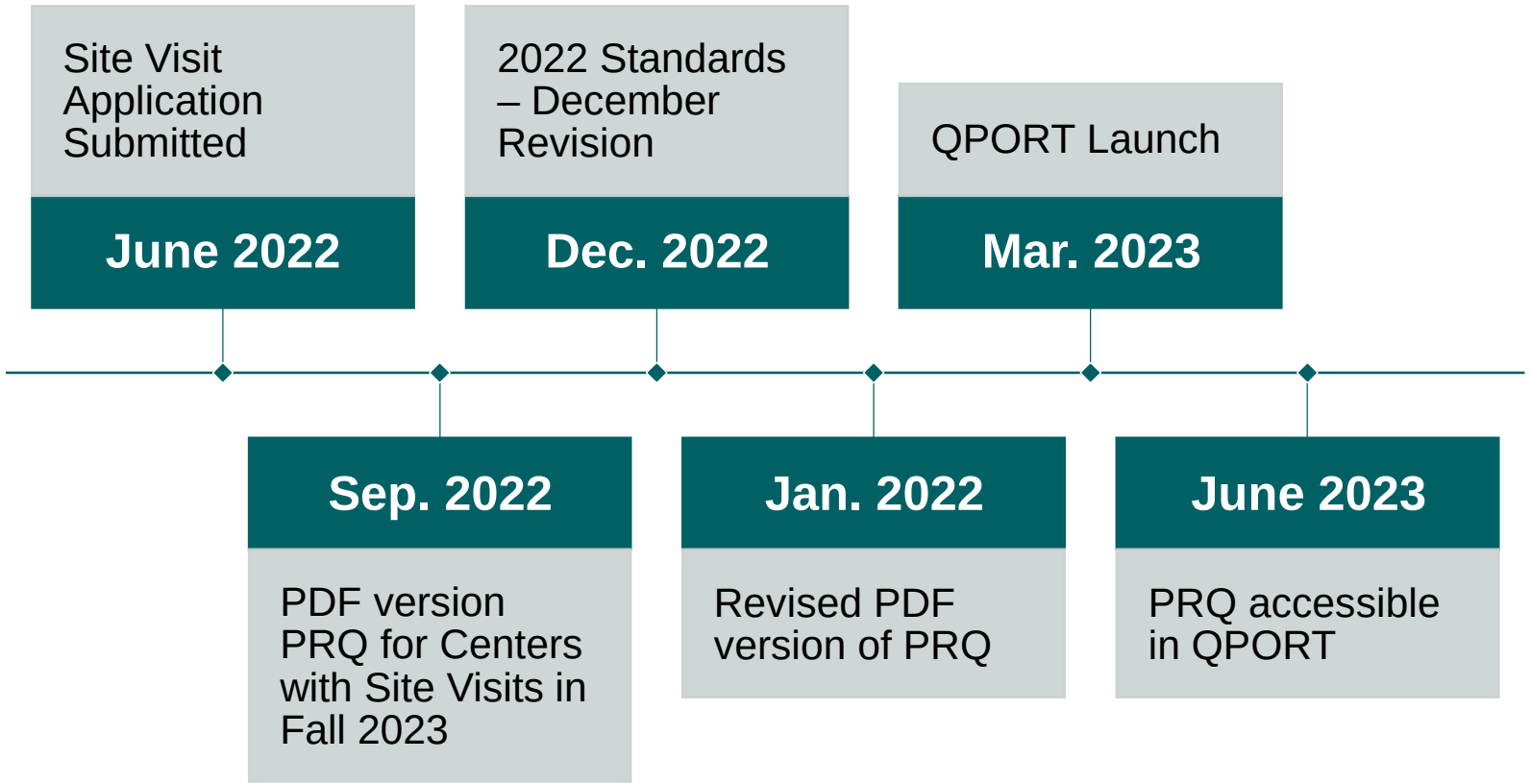
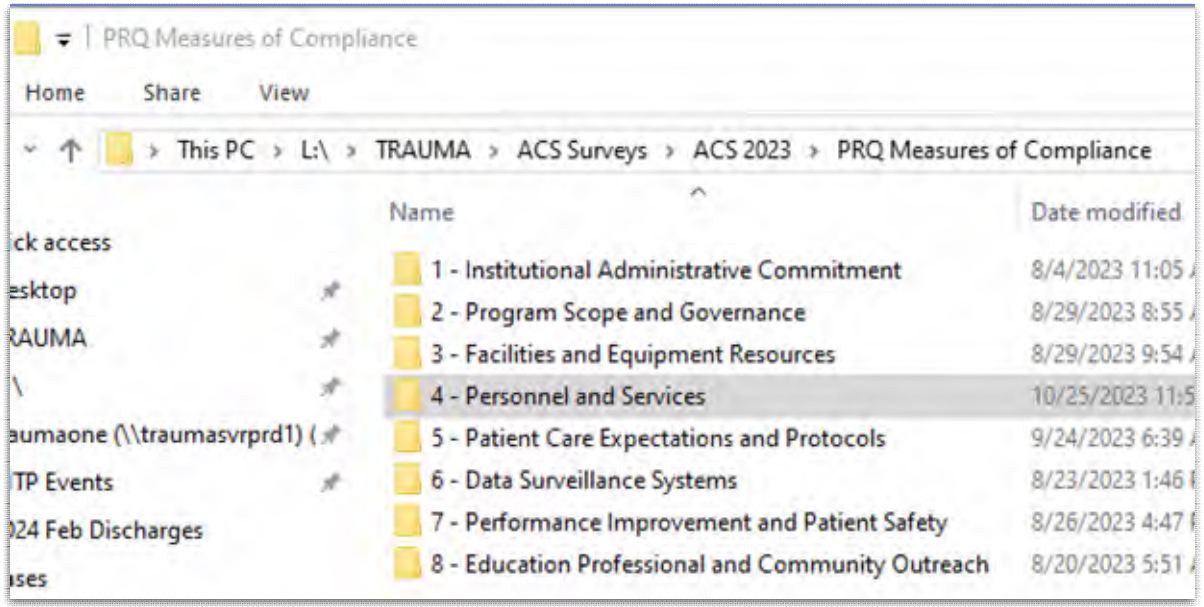
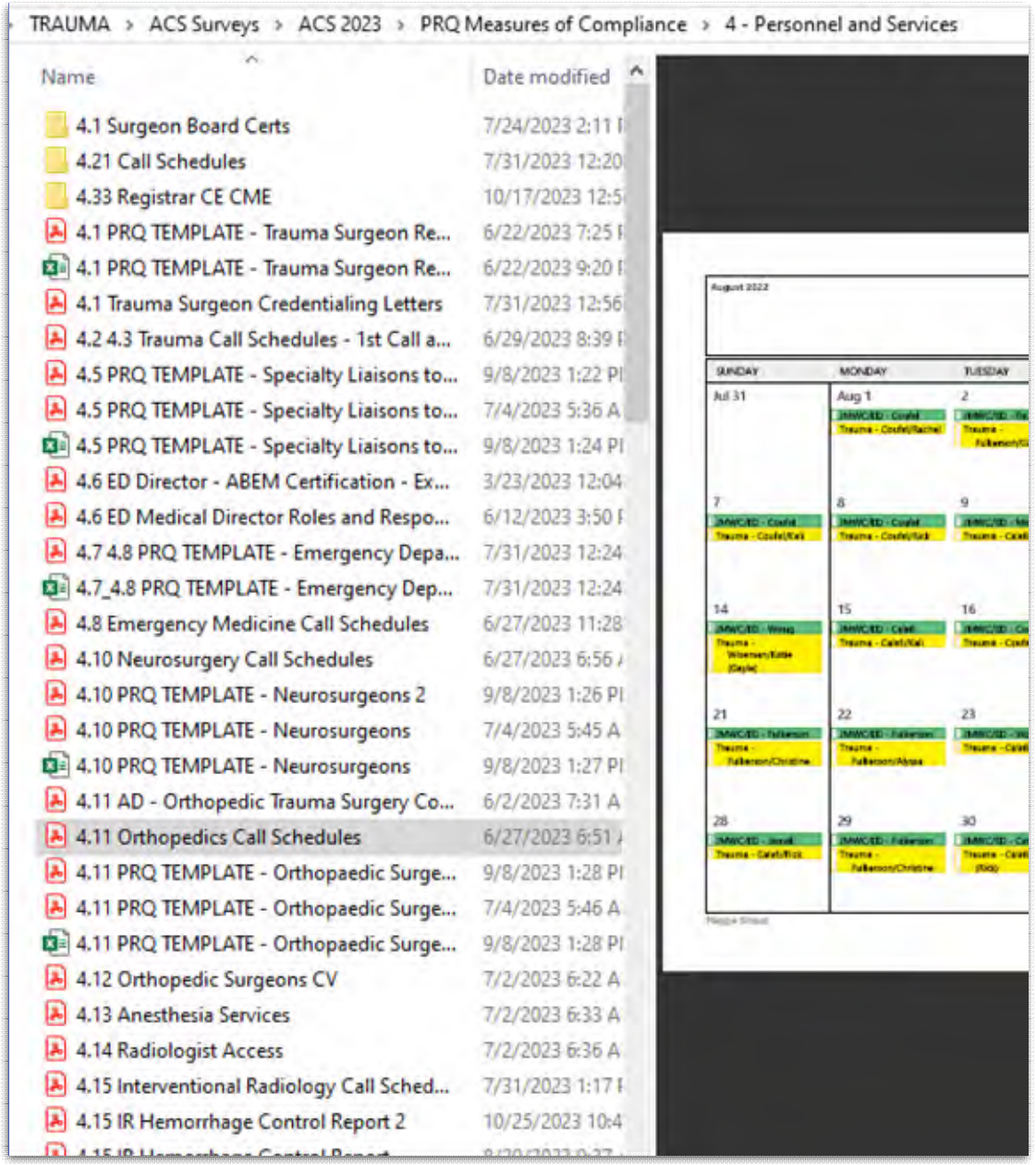
Survey Prep – Timeline



- *Videoconferencing software*
- *Onsite logistics coordinator*
- *HIPAA-compliant file sharing*
- *Live tour prep*
- *Adobe Acrobat Pro access*

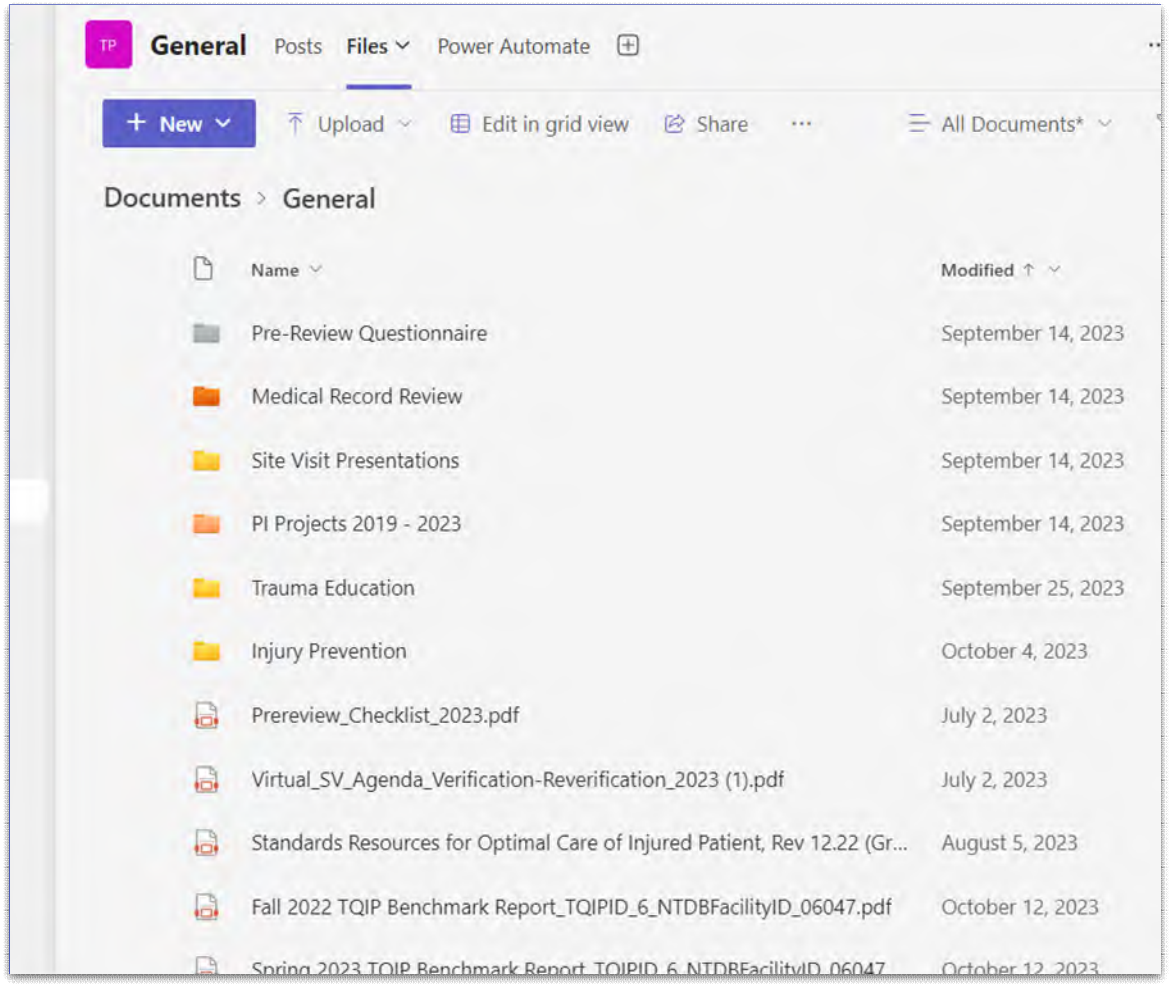
Survey Prep – “Binders”





Survey Prep – Team Prep

- June 2023: PRQ accessible in QPORT
  - 6/29/23 Renewal Visit Confirmed
  - 7/7/23 Pre-Review Call Scheduled
- Sept 7 2023: JMMC PRQ submitted
  - 9/8/23 PRQ Validation from ACS
  - 9/14/23 Chart Review Template uploaded; immediate reply by lead reviewer
  - 10/3/23 Charts sent to reviewers



Site Survey

Day 1 – Thurs, 10/26/23

Introductions
Medical Record Review
Lunch
TQIP Report Review
Review of Program Documents
Review Meeting

Day 2 – Fri, 10/27/23

Hospital Tour
Meeting with TMD / TPM / TPM & TMD
Review Team Closed Meeting
Exit Interview

- *Cell phone numbers for everyone*
- *Brief means brief*
- *Practice, practice, practice*

Survey Results – Non Compliant

5.17 Neurosurgeon Response

DASHBOARD - By Discharge Date	GOAL	OCT	NOV	DEC	JAN - 24	FEB
NS Response within 30 min, %	80%	66.7%	88.2%	100.0%	100.0%	100.0%

The neurosurgical response for patients meeting 30 minute response criteria is 26%. 10% of the time, evaluation was beyond 30 minutes. Neurosurgical response was not documented 69% of the time.

-- In conjunction with Neurosurgery, implement a system that accurately captures neurosurgical response. Data should be presented quarterly at Trauma Systems and Neurosurgery department meetings to assure compliance.

5.21 Orthopaedic Surgeon Response

DASHBOARD - By Discharge Date	GOAL	OCT	NOV	DEC	JAN - 24	FEB
Ortho Response within 30 min, %	80%	0.0%	50.0%	100.0%	100.0%	

Orthopedics was present within 30 minutes for patients meeting criteria 14% of the time. Response was not documented 76% of the time.

--In conjunction with Orthopedic Surgery, implement a system that will reliably capture orthopedic response. Report this data quarterly at Trauma Systems and Orthopedic department meetings to assure compliance.

5.31 Alcohol Misuse Intervention

DASHBOARD - By Discharge Date	GOAL	OCT	NOV	DEC	JAN - 24	FEB
SBI Screen Rate, Admits exclude Deaths	80%	70.6%	79.1%	79.1%	82.0%	92.0%
SBI Intervention Rate, Admits exclude Deat	80%	94.7%	94.4%	100.0%	95.0%	100.0%
ITSS Screen Rate, Admits exclude Deaths	80%	64.7%	65.7%	71.6%	73.0%	83.0%

Intervention was performed in 64% of patients who screened positive for alcohol abuse.

-- Implement a system that will consistently identify patients who screen positive for alcohol misuse. Improve social service or other resources to assure compliance with alcohol misuse interventions and mental health screening.

Survey Results – OFI

2.11 Trauma Program Manager Responsibilities and Reporting Structure	The reporting structure does not provide the TPM direct access to the C suite. *-- To facilitate Trauma Program Manager oversight of the program, consider a change in organizational structure that allows direct access to Vice President level administration such as the CNO.*
3.7 Cerebral Monitoring Equipment	The rate of ICP monitoring is low and there is variation in strategies to follow the TBI patient. *--Develop a multidisciplinary, data driven protocol that is agreeable to major stakeholders. Review all patients with a GCS < 9 that did not receive intracranial pressure monitoring after resuscitation.*
4.8 Emergency Department Physician Coverage	ED physicians respond to inhouse codes potentially leaving the ED uncovered in early morning hours. *--Ensure the emergency department is covered at all times.*
4.15 Interventional Radiology Response for Hemorrhage Control	IR Puncture time for hemorrhage control occurred within 60 minutes in 67% of cases. *-- Develop reliable methods for notification and response of the IR team. Ensure the team is able to consistently meet the one-hour standard for puncture.*
5.8 Massive Transfusion Protocol	Case review suggests that thromboelastography is under utilized during massive transfusions. The process to obtain emergency release blood is cumbersome due to lack of an Emergency Department blood refrigerator. *--Encourage routine use of thromboelastography for coagulation management. Include thromboelastography results when reviewing massive transfusion cases. Dedicate the necessary resources to obtain a ED blood refrigerator.*

Survey Results – OFI

7.3 Documented Effectiveness of the PIPS Program	Not all issues are consistently identified at primary review. Case review identified several complex cases that may have benefited from secondary review. Not all issues are discussed at multidisciplinary committee. Peer review minutes lack discussions details that lead to adjudication. Not all patients transferred for acute care are reviewed. *--Ensure the appropriate details have been reviewed before closure at primary review. Reassess which cases should be forwarded for secondary review. Identify all significant issues at secondary review and include a list of specific issues that must be adjudicated at committee. Additional PI staff and an Associate Trauma Director may be necessary to achieve these goals.*
7.4 Participation in Risk-Adjusted Benchmarking Programs	The program did not submit isolated hip fracture data to TQIP as outlined in the NTDB inclusion criteria. *--Begin submission of isolated hip fracture data to TQIP. Based upon current registry staffing, this additional volume of cases will likely require additional registrars for continued compliance with Standard 4.31.*
8.2 Nursing Trauma Orientation and Education	Trauma related ICU and PACU nursing certification is 0% and 3% respectively. Although the John Muir Trauma Essentials course is required, only 55% of ICU nurses have completed the Trauma Essentials course. *--In addition to the annual requirement of 6 trauma related CME, consider mandatory trauma related certifications such as TCAR.*

Notable Strengths

1.1 Administrative Commitment	The long standing administrative commitment to trauma patients benefits the region.
2.9 Trauma Medical Director Responsibility and Authority	The Trauma Medical Director, Dr. Sean Martin, is experienced, highly engaged, and an asset to the program.
2.10 Trauma Program Manager Requirements	The Trauma Program Manager, Kristin Santos, is knowledgeable and provides experienced leadership to the program.
2.12 Injury Prevention Program	JMH's injury prevention program is extensive. The violence prevention program led by Laura Pooler, benefits the region.
3.1 Operating Room Availability	There is a dedicated trauma room with staffing available at all times.
4.11 Orthopaedic Trauma Care	The orthopaedic commitment to care demonstrated by fixation of femur and open tibia fractures in less than one third of the time experienced in other TQIP hospitals.
4.12 Specialized Orthopaedic Trauma Care	3 OTA surgeons allow complex pelvic fracture cases to remain at the center.
4.20 ICU Nursing Staffing Requirement	ICU nursing's commitment to patient care evidenced by a detailed list of patients who require one on one nursing.
4.22 Ophthalmology Service	The depth of ophthalmology coverage and the availability of Oculoplastics benefits patient care.
6.2 Trauma Registry Patient Record Completion	Completion of 98% of patient records within 30 days is exemplary.
7.10 Prehospital Care Feedback	The bimonthly EMS case review and use of the Contra Costa EMS Event Reporting system provides timely feedback to EMS.
8.1 Public and Professional Trauma Education	The success of the violence protection program led by Laura Pooler benefits the community.

COTVRC <COTVRC@facs.org>
To Kristin Santos
Cc cotvrc@facs.org; alathrop@hsd.cccounty.us; jbarger@hsd.cccounty.us
You forwarded this message on 1/29/2024 11:36 AM.

Reply | Reply All | Forward | ... Mon 1/29/2024 11:23 AM

ACS VRC

Verification Review Consultation
American College of Surgeons

January 29, 2024

John Muir Medical Center, Walnut Creek
1601 Ygnacio Valley Road
Walnut Creek, CA 94598

The ACS Committee on Trauma would like to extend its congratulations to John Muir Medical Center, Walnut Creek on its Level II Renewal Verification for a period of one year through 11/7/2024.

To access the report, log in to the ACS Quality Portal (QPort) and click on Site Visit History.

To extend the verification period an additional two years, the hospital must complete a corrective action review by documentation. Documentation must be submitted that reflects the following:

- Standard 5.17: Submit de-identified documentation demonstrating neurosurgical evaluation based on the criteria noted in the standard within 30 minutes for a period of 6 months following the conclusion of the site visit.
- Standard 5.21: Submit de-identified documentation demonstrating orthopaedic evaluation based on the criteria noted in the standard within 30 minutes for a period of 6 months following the conclusion of the site visit.
- Standard 5.31: Submit de-identified documentation demonstrating at least 80% of patients who screened positive for alcohol misuse receive a brief intervention for a period of 6 months following the conclusion of the site visit.

The required corrective action documentation must be submitted to cotvrc@facs.org prior to 10/27/2024.

The ACS Committee on Trauma's certificate of verification will arrive in the mail within the next several weeks. Thank you for your continued participation and support of the Verification, Review, and Consultation Program. As always, we will be glad to answer any questions you may have and look forward to working with your trauma center in the future.

Regards,

The Verification, Review, and Consultation Program
American College of Surgeons

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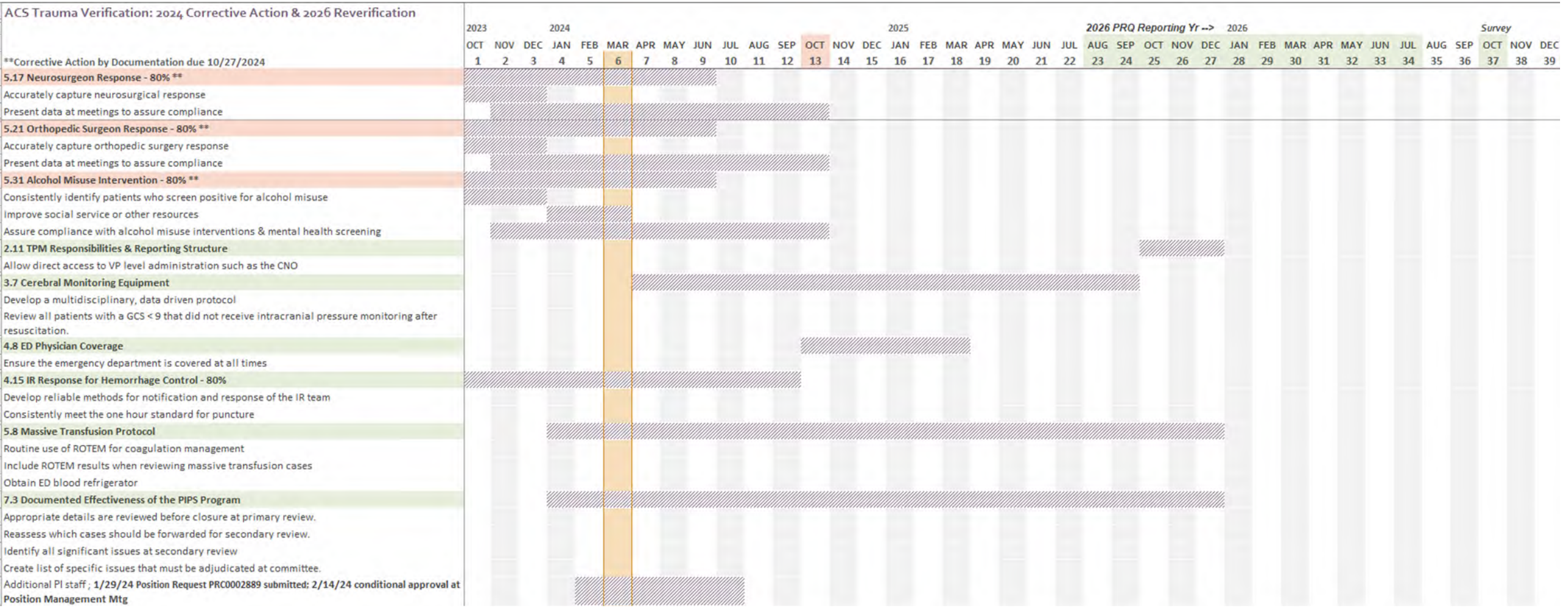
Ongoing Survey Readiness



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