



Verification Review Consultation
American College of Surgeons

Executive Summary

Level III Trauma Center

Renewal

Verification Through: 01/11/2029

Site Name:	HCA TriStar StoneCrest Medical Center 200 StoneCrest Blvd Smyrna, TN, United States 37167
Site ID:	17185
Site Visit Date:	January 06, 2026
Site Reviewer(s):	John Patrick Hunt III, MD FACS Lisa Patterson, MD FACS
Status:	Verified

Verification Report

Site ID: 17185
 Site Name: HCA TriStar StoneCrest Medical Center
 Program Selection: III
 Site Visit Date: 01/06/2026

Opportunities for Improvement

Standard	Comment
2.11 Trauma Program Manager Responsibilities and Reporting Structure	The TPM and PIC have a large work burden covering the PIPS program and have set up outstanding injury prevention and education programs. Monitor to ensure resources are appropriate to maintain these trauma center functions.
5.3 Levels of Trauma Activation	Geriatric trauma activation for hypotension was added to criteria, but at level II. It was discussed that the geriatric patients can have non-trauma reasons for hypotension. The recommendation is to evaluate how activating at the highest level for SBP< 110 would impact the number of highest level activations.
5.18 Neurotrauma Plan of Care for Level III Trauma Centers	The policy doesn't delineate which neurotrauma patients can be admitted. For example, they have orthopaedic spine coverage, but the policy does not delineate which patients are kept and which are transferred. They are working with the local level I trauma center to implement Brain Injury Guidelines (BIG) in order to keep minor TBI patients.
7.3 Documented Effectiveness of the PIPS Program	The program at times may consider quantity over quality in the case review process. There were certain cases reviewed where discussion of the clinical care and measures taken could have been more in-depth. The PIPS program does a good job of identifying and solving system problems.
8.2 Nursing Trauma Orientation and Education	This institution sees a very low volume of ICU level trauma patients. ICU nursing trauma education was identified as an OFI for the last site visit. TCAR has been implemented, targeting nursing leadership first with 60% compliance. ICU TCAR education is ongoing but still at a low rate due to turnover.

Strengths

Verification Report

Site ID: 17185
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Standard	Comment
1.1 Administrative Commitment	The administration enthusiastically supports the trauma program. This is demonstrated by the provision of more than adequate resources and participation in the PIPS process. The CEO will be leaving and should be replaced with someone who will ensure the same level of commitment.
2.1 State and Regional Involvement	Both the TMD and TPM are active members and hold leadership positions in the state trauma system.
2.2 Hospital Regional Disaster Committee	The center is active in disaster preparation and drills in the state and region.
2.8 Trauma Medical Director Requirements	The TMD is an asset to the program and has moved the program forward in improving patient care.
2.10 Trauma Program Manager Requirements	The TPM has a background as an EMT which is advantageous. The TPM, along with the PIC, have organized a well run and detailed PIPS program. Their additional contributions to the prevention and education efforts of the program are noteworthy.
2.12 Injury Prevention Program	In regards to the Stop the Bleed educational efforts, they are quite extensive and impressive for a level III trauma center. Hospital administration provides financial support for this important community effort in terms of donated STB kits.
4.11 Orthopaedic Trauma Care	There are 3 different orthopaedic groups that provide coverage and they work collaboratively. One group is orthopaedic spine which allows this institution to keep spine fractures that would otherwise need to be transferred out.
5.10 Pediatric Readiness	Pediatric readiness score is 96%. This is a marked improvement from the last visit.

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5.12 Transfer Protocols	The program has a commendable record for identifying early and transferring patients that have injuries that exceed their capabilities.
6.2 Trauma Registry Patient Record Completion	Although registry staffing barely meets the minimum requirement, their time to chart completion is exemplary with charts frequently completed within 30 days.
7.8 Nonsurgical Trauma Admissions Review	The program has a comprehensive process for evaluating non-surgical admissions.

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Overall Comments

This is a high functioning level III trauma center that is of great value to the community. It receives commendable support from the administration. The leadership of the program, the TMD, TPM, and PIC are assets and have brought the program a long way.



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Category 1: Institutional Administrative Commitment

1.1 Administrative Commitment	Compliant
The administration enthusiastically supports the trauma program. This is demonstrated by the provision of more than adequate resources and participation in the PIPS process. The CEO will be leaving and should be replaced with someone who will ensure the same level of commitment.	
Notable Strength	



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Category 2: Program Scope and Governance

2.1 State and Regional Involvement	Compliant
Both the TMD and TPM are active members and hold leadership positions in the state trauma system.	
Notable Strength	
2.2 Hospital Regional Disaster Committee	Compliant
The center is active in disaster preparation and drills in the state and region.	
Notable Strength	
2.3 Disaster Management Planning	Compliant
2.6 Adult Trauma Centers Admitting Pediatric Patients	Compliant
2.7 Trauma Multidisciplinary PIPS Committee	Compliant
2.8 Trauma Medical Director Requirements	Compliant
The TMD is an asset to the program and has moved the program forward in improving patient care.	
Notable Strength	
2.9 Trauma Medical Director Responsibility and Authority	Compliant



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Category 2: Program Scope and Governance

2.10 Trauma Program Manager Requirements	Compliant
The TPM has a background as an EMT which is advantageous. The TPM, along with the PIC, have organized a well run and detailed PIPS program. Their additional contributions to the prevention and education efforts of the program are noteworthy.	
Notable Strength	
2.11 Trauma Program Manager Responsibilities and Reporting Structure	Compliant
The TPM and PIC have a large work burden covering the PIPS program and have set up outstanding injury prevention and education programs. Monitor to ensure resources are appropriate to maintain these trauma center functions.	
Opportunity for Improvement	
2.12 Injury Prevention Program	Compliant
In regards to the Stop the Bleed educational efforts, they are quite extensive and impressive for a level III trauma center. Hospital administration provides financial support for this important community effort in terms of donated STB kits.	
Notable Strength	
2.13 Organ Procurement Program	Compliant
This is a low volume level III trauma center with no neurosurgical capability, so they had no organ donors from trauma.	



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Category 3: Facilities and Equipment Resources

3.1 Operating Room Availability	Compliant
3.3 Operating Room for Orthopaedic Trauma Care	Compliant
3.4 Blood Products	Compliant
3.5 Medical Imaging	Compliant



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Category 4: Personnel and Services

4.1 Trauma Surgeon Requirements	Compliant

4.2 Trauma Surgeon Coverage	Compliant

4.3 Trauma Surgery Backup Call Schedule	Compliant

4.4 Trauma Surgeon Presence in Operating Room	Compliant

4.5 Specialty Liaisons to the Trauma Service	Compliant

4.6 Emergency Department Director	Compliant

4.7 Emergency Department Physician Requirements	Compliant

4.11 Orthopaedic Trauma Care	Compliant
There are 3 different orthopaedic groups that provide coverage and they work collaboratively. One group is orthopaedic spine which allows this institution to keep spine fractures that would otherwise need to be transferred out.	
Notable Strength	



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Category 4: Personnel and Services

4.13 Anesthesia Services	Compliant
4.14 Radiologist Access	Compliant
4.16 ICU Director	Compliant
4.19 ICU Provider Coverage for Level III Trauma Centers	Compliant
4.20 ICU Nursing Staffing Requirement	Compliant
The nursing ratio is 2:1 for ICU patients.	
4.26 Medical Specialists	Compliant
4.28 Allied Health Services	Compliant
4.29 Renal Replacement Therapy Services	Compliant
4.30 Advanced Practice Providers	Compliant



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Category 4: Personnel and Services

All of the APPs listed in the PRQ are in the Emergency Department. They are considering utilizing APPs for the Trauma/Acute Care Surgery service which would be of tremendous benefit for patient care, continuity, and improving length of stay.

4.31 Trauma Registry Staffing Requirements	Compliant
<p>There are 2 full time registrars at this facility (2.0 FTE) as well as an additional 0.5 FTE distributed across 3 individuals, all dedicated to this facility. A new trauma registry was implemented in April 2025. At the site visit, PRQ discrepancies about the number of registry entries were reviewed. For the review year, a total of 1575 entries were done. However, 316 of these entries utilized outside registry resources available through the HCA system shared service model. Based on this, the number of registrars is compliant with the ACS standard. They are actively recruiting for additional registrar staff.</p>	
4.32 Certified Abbreviated Injury Scale Specialist	Compliant
4.33 Trauma Registry Courses	Compliant
Dell AIS 2015 certification was provided.	
4.34 Trauma Registrar Continuing Education	Compliant
4.35 Performance Improvement Staffing Requirements	Compliant



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Category 5: Patient Care: Expectations and Protocols

5.1 Clinical Practice Guidelines	Compliant
5.2 Trauma Surgeon and Emergency Medicine Physician Shared Responsibilities	Compliant
5.3 Levels of Trauma Activation	Compliant
Geriatric trauma activation for hypotension was added to criteria, but at level II. It was discussed that the geriatric patients can have non-trauma reasons for hypotension. The recommendation is to evaluate how activating at the highest level for SBP< 110 would impact the number of highest level activations.	
Opportunity for Improvement	
5.4 Trauma Surgeon Response to Highest Level of Activation	Compliant
5.5 Trauma Surgical Evaluation for Activations below the Highest Level	Compliant
5.7 Assessment of Children for Nonaccidental Trauma	Compliant
5.8 Massive Transfusion Protocol	Compliant
5.9 Anticoagulation Reversal Protocol	Compliant



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Category 5: Patient Care: Expectations and Protocols

5.10 Pediatric Readiness	Compliant
Pediatric readiness score is 96%. This is a marked improvement from the last visit.	
Notable Strength	
5.11 Emergency Airway Management	Compliant
5.12 Transfer Protocols	Compliant
The program has a commendable record for identifying early and transferring patients that have injuries that exceed their capabilities.	
Notable Strength	
5.13 Decision to Transfer	Compliant
5.14 Transfer Communication	Compliant
5.15 Trauma Diversion Protocol	Compliant
5.16 Trauma Diversion Hours	Compliant
There was only one episode of diversion lasting 11 hours and it was due to miscommunication by a new administrator on-call who did not follow the protocol.	



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Category 5: Patient Care: Expectations and Protocols

5.18 Neurotrauma Plan of Care for Level III Trauma Centers	Compliant
The policy doesn't delineate which neurotrauma patients can be admitted. For example, they have orthopaedic spine coverage, but the policy does not delineate which patients are kept and which are transferred. They are working with the local level I trauma center to implement Brain Injury Guidelines (BIG) in order to keep minor TBI patients.	
Opportunity for Improvement	
5.20 Treatment Guidelines for Orthopaedic Injuries	Compliant
5.21 Orthopaedic Surgeon Response	Compliant
5.22 Operating Room Scheduling Policy	Compliant
5.23 Surgical Evaluation of ICU Patients	Compliant
5.24 Trauma Surgeon Responsibility for ICU Patients	Compliant
5.25 Communication of Critical Imaging Results	Compliant
5.26 Timely Computed Tomography Scan Reporting	Compliant



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Category 5: Patient Care: Expectations and Protocols

5.27 Rehabilitation Services during Acute Phase of Care	Compliant
5.28 Rehabilitation and Discharge Planning	Compliant
5.29 Mental Health Screening	Compliant
5.30 Alcohol Misuse Screening	Compliant
Although they meet the standard for screening, they use only CAGE for screening.	
5.31 Alcohol Misuse Intervention	Compliant



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Category 6: Data Surveillance and Systems

6.1 Data Quality Plan	Compliant
6.2 Trauma Registry Patient Record Completion	Compliant
Although registry staffing barely meets the minimum requirement, their time to chart completion is exemplary with charts frequently completed within 30 days.	
Notable Strength	
6.3 Trauma Registry Data Collection and Submission	Compliant



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Category 7: Performance Improvement and Patient Safety

7.1 Trauma PIPS Program	Compliant
7.2 PIPS Plan	Compliant
7.3 Documented Effectiveness of the PIPS Program	Compliant
<p>The program at times may consider quantity over quality in the case review process. There were certain cases reviewed where discussion of the clinical care and measures taken could have been more in-depth. The PIPS program does a good job of identifying and solving system problems.</p> <p>Opportunity for Improvement</p>	
7.4 Participation in Risk-Adjusted Benchmarking Programs	Compliant
7.5 Physician Participation in Prehospital Performance Improvement	Compliant
7.6 Trauma Multidisciplinary PIPS Committee Attendance	Compliant
<p>One trauma surgeon was at the minimum of 50% attendance but this was not identified as an OFI as he was seriously injured, was out for months, and had a slow return to his duties.</p>	
7.7 Trauma Mortality Review	Compliant
7.8 Nonsurgical Trauma Admissions Review	Compliant



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Category 7: Performance Improvement and Patient Safety

The program has a comprehensive process for evaluating non-surgical admissions.

Notable Strength

7.9 Trauma Diversions Review

Compliant

One episode of diversion for 11 hours was reviewed through the systems committee.

7.10 Prehospital Care Feedback

Compliant



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Category 8: Education: Professional and Community

8.1 Public and Professional Trauma Education	Compliant

8.2 Nursing Trauma Orientation and Education	Compliant
This institution sees a very low volume of ICU level trauma patients. ICU nursing trauma education was identified as an OFI for the last site visit. TCAR has been implemented, targeting nursing leadership first with 60% compliance. ICU TCAR education is ongoing but still at a low rate due to turnover.	
Opportunity for Improvement	

8.3 Prehospital Provider Training	Compliant



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Case Review Template

Trauma Center Name: HCA Tristar Stonecrest Medical Center

CASE # 1

Injury Category	GCS	ISS
Abdomen/Thoracic injury	15	4
Narrative - Include a brief overall summary of the case, detailing the scope of the patient's care from injury to discharge.		
<p>This 40-year-old male arrived by personal vehicle and had a gunshot wound to the lower abdomen. He was a Level I activation. The patient had a GCS -15. BP – 80/47, HR – 89, RR – 18. The trauma surgeon arrived 23 minutes after activation. The MTP was activated and the patient received 4 units of PRBCs and 4 units of FFP before going to the OR. FAST exam was positive. The patient was in the OR 1 hour 2 minutes after arrival. The patient had a pelvic hematoma and a recto-sigmoid injury that required resection and colostomy. He was admitted to the ICU and developed agitation secondary to alcohol. A drain showed increasing output and a high creatinine and Urology was consulted. CT cystogram was inconclusive and Urology did cystoscopy and retrograde ureterogram demonstrating right distal ureteral injury. IR was not available to do a percutaneous nephrostomy tube. He was in the ICU for 8 days and extubated hospital day 6 and was sent to a higher level of care where he had a percutaneous nephrostomy placed. His ureteral injury was repaired later by this facility.</p>		
PI Summary - Include a summary of all performance improvement measures taken by the program in response to the case, including all corrective action and loop closure.		
<p>The case went to tertiary review. There was a delay in diagnosis of a missed ureteral injury. The Radiology department and Urology were involved, and the IR team is now available 24 hours, seven days a week. The head of Radiology will be called if there is any issue in getting IR involved in a case.</p>		
Reviewer Comments - Include a statement discussing appropriateness of care.		
<p>The PIPS process covered the system issues in this case well. The missed ureteral injury itself was not covered in detail as covered in the PIPS meeting minutes for this case. A more detailed discussion on the missed injury and the steps taken or potential steps taken to avoid it was warranted.</p>		
Applicable Standard - If the Reviewer Comments are pertinent to a non-compliant standard, include the applicable standard(s).		

Case Review Template

CASE # 2

Injury Category	GCS	ISS
Abdominal/Thoracic Injury	15	9
<p>Narrative - Include a brief overall summary of the case, detailing the scope of the patient's care from injury to discharge.</p> <p>This 55-year-old female was involved in a motor vehicle crash. Dispatch, scene, transport times of 6, 19, and 11 minutes. She had a GCS -15, BP – 162/113, HR – 130, RR - 20. She was not activated. She was not initially evaluated by the trauma team. She was seen by the ED. The initial ED vital signs were HR – 121, BP – 128/83, RR – 17, GCS – 15. The patient had a CT scan which showed hemoperitoneum and a possible spleen injury. It took 1 hour and 57 minutes to do the CT. She was in the ED for 4 hours and 49 minutes before being sent to the ICU. Post injury day 1, she had a drop in hemoglobin and some mild hypotension. Laparoscopic exploration showed a splenic laceration that was handled with splenorrhaphy with fibrin glue and surgical. She was in the ICU for 2 days and had a total hospital stay of 4 days. She was seen by Internal Medicine and the surgeon in the ICU and the surgeon on the floor. She was sent home.</p>		
<p>PI Summary - Include a summary of all performance improvement measures taken by the program in response to the case, including all corrective action and loop closure.</p> <p>This case went to tertiary review. The FAST exam was not done and fell out. The ED Liaison was informed and passed this on to the provider.</p>		
<p>Reviewer Comments - Include a statement discussing appropriateness of care.</p> <p>Care appropriate. PI complete.</p>		
<p>Applicable Standard - If the Reviewer Comments are pertinent to a non-compliant standard, include the applicable standard(s).</p>		

Case Review Template

CASE # 3

Injury Category	GCS	ISS
Hospice	14	4
<p>Narrative - Include a brief overall summary of the case, detailing the scope of the patient's care from injury to discharge.</p> <p>This 82-year-old female was involved in a ground level fall. Dispatch, scene, transport times of 3, 17, and 5 minutes. Vital signs at the scene were BP – 164/53, HR – 53, RR – 16 and the GCS was 15. The patient was a Level II activation. The ED vital signs were HR – 53, BP sys – 146/73, and RR – 15. She had a GCS – 14. She had a history of dementia. She had a pelvis CT 22 minutes after arrival and was diagnosed with a pubic rami fracture. She was admitted by the hospitalist. The trauma surgeon saw the patient the next day. Orthopaedics recommended non-operative management. She was in the hospital for 1 day and the family had the patient transferred to hospice secondary to her underlying diagnoses.</p>		
<p>PI Summary - Include a summary of all performance improvement measures taken by the program in response to the case, including all corrective action and loop closure.</p> <p>The case was reviewed at PIPs for non-surgical admit and found to have no opportunity for improvement.</p>		
<p>Reviewer Comments - Include a statement discussing appropriateness of care.</p> <p>Care appropriate.</p>		
<p>Applicable Standard - If the Reviewer Comments are pertinent to a non-compliant standard, include the applicable standard(s).</p>		

Case Review Template

CASE # 4

Injury Category	GCS	ISS
Mortality without opportunity for improvement	3	16
Narrative - <i>Include a brief overall summary of the case, detailing the scope of the patient's care from injury to discharge.</i>		
This 21-year-old male sustained a gunshot wound to the chest. On EMS arrival, the patient was pulseless and apneic and in cardiac arrest. CPR was initiated. The dispatch time was 9 minutes, scene time 10 minutes, and transport time was 3 minutes. On arrival in the ED, he still had no vital signs. He was a Level I activation. The trauma surgeon was present 6 minutes after arrival. Bilateral chest tubes were placed, there was no return of vital signs, and the patient was pronounced after 20 minutes.		
PI Summary - <i>Include a summary of all performance improvement measures taken by the program in response to the case, including all corrective action and loop closure.</i>		
The case went to primary, secondary, and tertiary review. There was no opportunity for improvement noted.		
Reviewer Comments - <i>Include a statement discussing appropriateness of care.</i>		
Care appropriate and PI good.		
Applicable Standard - <i>If the Reviewer Comments are pertinent to a non-compliant standard, include the applicable standard(s).</i>		

Case Review Template

CASE # 5

Injury Category	GCS	ISS
Mortality without opportunity for improvement.	15	10
<p>Narrative - Include a brief overall summary of the case, detailing the scope of the patient's care from injury to discharge.</p> <p>This 79-year-old female fell from her own height. She had a history of dementia. Dispatch, scene, transport times were 12, 45, and 8 minutes, respectively. Initial field vital signs were BP - 132/60, HR – 90, RR – 22, GCS – 8. The GCS improved in the field. The patient was not an activation. The initial ED vital signs were HR – 91, BP 114/78, RR – 25 and a GCS of 15. She had a small pneumothorax by CXR and rib fractures. A chest tube was placed by the ED physician. She also had a hilar mass on imaging and an extensive history of COPD. The patient was admitted to the ICU by the hospitalist. The patient was seen the next day by the trauma surgeon. The patient was made a DNR and expired on hospital day 7.</p>		
<p>PI Summary - Include a summary of all performance improvement measures taken by the program in response to the case, including all corrective action and loop closure.</p> <p>This case was reviewed in primary, secondary, and tertiary review as a death and NSA. Nelson score was 5. There was no opportunity for improvement.</p>		
<p>Reviewer Comments - Include a statement discussing appropriateness of care.</p> <p>Care appropriate. The patient expired from pre-existing disease. PI thorough.</p>		
<p>Applicable Standard - If the Reviewer Comments are pertinent to a non-compliant standard, include the applicable standard(s).</p>		

Case Review Template

CASE # 6

Injury Category	GCS	ISS
Mortality with opportunity for improvement	15	16
<p>Narrative - Include a brief overall summary of the case, detailing the scope of the patient's care from injury to discharge.</p> <p>This was the case of a 74-year-old female who sustained a ground level fall. She was a walk-in and a delayed Level II activation. The initial ED vital signs were HR – 114, BP - 65/43, RR – 24 and a GCS of 15. The patient was in the ED for 7 hours and 30 minutes. She was diagnosed with a hip fracture and humerus fracture. She developed hypotension in the ED and vasopressors were started. She required intubation. She was diagnosed with a myocardial infarction and cardiogenic shock. She went into cardiac arrest and could not be resuscitated.</p>		
<p>PI Summary - Include a summary of all performance improvement measures taken by the program in response to the case, including all corrective action and loop closure.</p> <p>The case was reviewed in primary, secondary, and tertiary review as a death. There was a delay in the ED physician being notified of the patient's vital signs. The vital signs were put in the HER, but the ED physician not notified. The nurse was counselled. The case went to quaternary review. Tracking of hallway patients, overflow in ED, and the nursing vital sign tracking were instituted because of this case. Autopsy confirmed the diagnosis of MI.</p>		
<p>Reviewer Comments - Include a statement discussing appropriateness of care.</p> <p>Good PIPS analysis and institution of clinical changes. This case demonstrates the program's ability to identify system wide problems and institute solutions across disciplines. The program is able to retrieve autopsy findings.</p>		
<p>Applicable Standard - If the Reviewer Comments are pertinent to a non-compliant standard, include the applicable standard(s).</p>		

Case Review Template

CASE # 7

Injury Category	GCS	ISS
Non-surgical admit	15	10
<p>Narrative - <i>Include a brief overall summary of the case, detailing the scope of the patient's care from injury to discharge.</i></p> <p>This 77-year-old female who sustained a femur fracture from a ground level fall. The patient came directly to the ED and was a Level II activation. The initial vital signs in the ED were BP – 163/92, HR – 97, RR – 18 with a GCS – 15. She had multiple rib fractures on the right. CT was otherwise normal. The patient was admitted by the hospitalist. She was seen by the trauma team the next day. She was in the hospital for 3 days and managed with the rib fracture clinical practice guideline.</p>		
<p>PI Summary - <i>Include a summary of all performance improvement measures taken by the program in response to the case, including all corrective action and loop closure.</i></p> <p>This case went to primary and secondary review. NSA with Nelson score of 5. The clinical practice guideline was followed.</p>		
<p>Reviewer Comments - <i>Include a statement discussing appropriateness of care.</i></p> <p>Care seems appropriate with appropriate PI spanning multiple areas of the hospital.</p>		
<p>Applicable Standard - <i>If the Reviewer Comments are pertinent to a non-compliant standard, include the applicable standard(s).</i></p>		

Case Review Template

CASE # 8

Injury Category	GCS	ISS
Orthopaedic injury	15	9
<p>Narrative - Include a brief overall summary of the case, detailing the scope of the patient's care from injury to discharge.</p> <p>This 50-year-old male shot himself in the leg with a nail gun. He was a walk-in and not activated. The initial vital signs in the ED were BP – 138/83, HR – 74, RR – 18 with a GCS – 15. The patient was found to have a femur fracture on CT scan. He was admitted by the hospitalist and orthopaedics was consulted. He went to the OR the next day for ORIF. The trauma team saw him the next day. His post-op course was uncomplicated. He was home on hospital day #2.</p>		
<p>PI Summary - Include a summary of all performance improvement measures taken by the program in response to the case, including all corrective action and loop closure.</p> <p>He was reviewed at the secondary level for NSA and found to have no opportunity for improvement.</p>		
<p>Reviewer Comments - Include a statement discussing appropriateness of care.</p> <p>Care appropriate. PI appropriate.</p>		
<p>Applicable Standard - If the Reviewer Comments are pertinent to a non-compliant standard, include the applicable standard(s).</p> <p>7.3 [OFI]</p>		

Case Review Template

CASE # 9

Injury Category	GCS	ISS
Transfer	15	9
<p>Narrative - Include a brief overall summary of the case, detailing the scope of the patient's care from injury to discharge.</p> <p>This case involves a 53-year-old male who had syncope with a ground level fall. Prehospital vital signs were BP – 148/78, HR 78, RR – 16, GCS – 15. He had a history of brain cancer. He was not activated. CT scan showed epidural hematoma. The initial vital signs in the ED were BP – 173/90, HR – 77, RR – 16 with a GCS – 15. The patient was in the ED for 1 hour and 29 minutes before being transferred to a higher level of care.</p>		
<p>PI Summary - Include a summary of all performance improvement measures taken by the program in response to the case, including all corrective action and loop closure.</p> <p>The case went to primary, secondary, tertiary review for transfer out. No problems identified.</p>		
<p>Reviewer Comments - Include a statement discussing appropriateness of care.</p> <p>Care appropriate. This case demonstrates the program's ability to rapidly identify and transfer patients that exceed their capabilities.</p>		
<p>Applicable Standard - If the Reviewer Comments are pertinent to a non-compliant standard, include the applicable standard(s).</p>		

Case Review Template

CASE # 10

Injury Category	GCS	ISS
Transfer	15	10
<p>Narrative - Include a brief overall summary of the case, detailing the scope of the patient's care from injury to discharge.</p> <p>This 15-year-old male sustained a blow to the head with a baseball bat with a loss of consciousness. He came in by personal vehicle. He was a category II activation. The initial vital signs in the ED were BP – 118/66, HR – 75, RR – 16 with a GCS – 15. Pulse ox was 100%. He was in the CT scan 22 minutes from arrival where he was found to have skull and facial fractures and an intraparenchymal hemorrhage. Upon this diagnosis, the patient was transferred to the Level I Pediatric trauma center. The patient was in the ED for 1 hour and 30 minutes prior to transfer. He spent 2 days at the pediatric tertiary care center, and the trauma program was informed of his care.</p>		
<p>PI Summary - Include a summary of all performance improvement measures taken by the program in response to the case, including all corrective action and loop closure.</p> <p>Reviewed at primary, secondary, and tertiary for transfer. There was opportunity for improvement noted.</p>		
<p>Reviewer Comments - Include a statement discussing appropriateness of care.</p> <p>Care appropriate. Commendable time to transfer out. Good communication with the receiving facility.</p>		
<p>Applicable Standard - If the Reviewer Comments are pertinent to a non-compliant standard, include the applicable standard(s).</p>		

Case Review Template

CASE # 11

Injury Category	GCS	ISS
Abdomen/thoracic	15	10
<p><i>Narrative - Include a brief overall summary of the case, detailing the scope of the patient's care from injury to discharge.</i></p> <p>A 43-year male was struck in the chest by a piece of wood from a saw. He presented to the ED by private vehicle. He was a Level II activation with stable vital signs and a negative FAST. He had a chest CT which showed a lung laceration without hemopneumothorax. He was admitted to trauma for observation after an ED length of stay of 6.5 hours. He had 2 CXRs which were negative. The trauma surgeon saw the patient almost 24 hours after arrival and he was then subsequently discharged.</p>		
<p><i>PI Summary - Include a summary of all performance improvement measures taken by the program in response to the case, including all corrective action and loop closure.</i></p> <p>Primary/secondary reviews noted prolonged ED length of stay with no OFI. Consult time is tracked.</p>		
<p><i>Reviewer Comments - Include a statement discussing appropriateness of care.</i></p> <p>Although care was acceptable, his length of stay could have been significantly shortened, thus saving resources. This reviewer looked at CT imaging and discussed with the TPM that one single follow-up CXR in 4-6 hours would have been sufficient and the patient could have been discharged. Also of note, this was an unrecognized undertriage based on their activation criteria of "penetrating trauma" to the torso. The TPM states it had previously been gunshot wound but was changed based on a previous reviewer. The recommendation was to change it back to gunshot wound, consistent with the grey book, so that they are actually being compliant with their activation criteria.</p>		
<p><i>Applicable Standard - If the Reviewer Comments are pertinent to a non-compliant standard, include the applicable standard(s).</i></p>		

Case Review Template

CASE # 12

Injury Category	GCS	ISS
Nonsurgical admission	15	10
<p>Narrative - Include a brief overall summary of the case, detailing the scope of the patient's care from injury to discharge.</p> <p>An 86-year-old female with hypertension sustained a same level fall. Vital signs were stable by EMS and on arrival to the ED. Injuries identified were a hip fracture and elbow laceration. She was admitted to the hospitalist and ortho was consulted. She was taken to the OR from the ED approximately 2 hours after arrival and underwent a hemiarthroplasty. SBIRT was done, VTE prophylaxis was started on POD #1, and she was discharged to rehab after a 4-day hospital stay. The discharge summary mentioned a new medication of Apixaban for 11 days.</p>		
<p>PI Summary - Include a summary of all performance improvement measures taken by the program in response to the case, including all corrective action and loop closure.</p> <p>Primary and secondary review for the nonsurgical admission deemed it appropriate.</p>		
<p>Reviewer Comments - Include a statement discussing appropriateness of care.</p> <p>There was no cervical collar placed by EMS in this elderly patient who fell which was not identified by the PI program. The choice of VTE prophylaxis is not standardized for the isolated hip fracture patients and is up to the individual surgeon according to the TPM.</p>		
<p>Applicable Standard - If the Reviewer Comments are pertinent to a non-compliant standard, include the applicable standard(s).</p>		

Case Review Template

CASE # 13

Injury Category	GCS	ISS
Mortality without OFI	3	5
Narrative - <i>Include a brief overall summary of the case, detailing the scope of the patient's care from injury to discharge.</i>		
<p>A 60-year-old female with diabetes and COPD on steroids fell out of bed the day prior to presentation. The family stated that she was more confused, and then unarousable. EMS noted a GCS 7, blood sugar < 20. She was given D50 and glucagon. Vital signs were stable, but they did not place a cervical collar and could not obtain IV access. They called medical control to get permission for an IO which was denied. On arrival to the ED, she was a second level trauma activation and vital signs were: BP 141/71, P93, R27, oxygen saturation 96%. Blood glucose was 12 and she was given D50. Approximately 20 minutes after arrival her SBP was 90/P. FAST was negative. Because she had an existing DNR/DNI, she was placed on bipap and admitted to the hospitalist to the ICU after an ED length of stay of ~3.5 hours. Imaging also showed evidence of CAP and sacral osteomyelitis associated with a decubitus ulcer. The trauma surgeon, which was the TMD, wrote a "brief consult" note ~ 4.5 hours after arrival, but the note did not include a physical exam. It stated that imaging was negative and that trauma would sign off. Imaging did note an acute L5 fracture which was not addressed. The patient ultimately was made CMO and expired after a 3-day hospital stay.</p>		
PI Summary - <i>Include a summary of all performance improvement measures taken by the program in response to the case, including all corrective action and loop closure.</i>		
<p>Primary to tertiary review occurred and noted ED length of stay > 2 hours and the NSA which was considered appropriate. In terms of mortality, the minutes stated she had poor baseline health and that there was no OFI.</p>		
Reviewer Comments - <i>Include a statement discussing appropriateness of care.</i>		
<p>Her prognosis was poor from the outset. However, there were several issues not addressed by the PI program. The first was undertriage as she had altered mental status and a recent trauma. Based on the history of progressive mental decline after the fall, this could have also been due to a TBI. This comatose patient who had fallen was not placed in a cervical collar and this seems to be a frequent occurrence at this institution. The EMS issue of not placing an IO should have at least been referred to ED/prehospital review. In terms of the trauma surgeon note, without a documented physical exam, it was not clear that the patient was actually seen. The TMD failed to identify the L5 fracture, and this was not a Radiology misread. Ultimately it was inconsequential to her outcome, but it should have been recognized and addressed through the PI program.</p>		
Applicable Standard - <i>If the Reviewer Comments are pertinent to a non-compliant standard, include the applicable standard(s).</i>		

Case Review Template

CASE # 14

Injury Category	GCS	ISS
Mortality without OFI	15	9
Narrative - Include a brief overall summary of the case, detailing the scope of the patient's care from injury to discharge.		
<p>A 74-year-old female with COPD and alcohol use sustained a same level fall 4 days prior to admission and she complained of neck pain. There was no trauma activation. She was diagnosed with a dens fracture. The Level I neurosurgeon was contacted and recommended cervical collar. Ortho spine was consulted, saw the patient, and recommended cervical collar for 3-4 weeks and noted there was risk of needing future surgery if the injury didn't heal. She was admitted to the hospitalist service and treated with antibiotics due to chest imaging showing concern for pneumonia. She had progressive respiratory failure and was transferred to the ICU on day 2, placed on a nonrebreather. She had a pre-existing DNR/DNI. Palliative care was consulted and she was made CMO and expired after a 4-day hospital stay.</p>		
PI Summary - Include a summary of all performance improvement measures taken by the program in response to the case, including all corrective action and loop closure.		
<p>This case was reviewed from primary to tertiary level. Nonsurgical admission was considered acceptable and the unplanned ICU admission was trended. The minutes on mortality review were brief and stated that she had severe COPD exacerbated by community acquired pneumonia and that care was appropriate.</p>		
Reviewer Comments - Include a statement discussing appropriateness of care.		
<p>The neuro policy is not clear as to what injuries they keep vs. transfer out. They have access to the Level I neurosurgical team for consultation, but they also have ortho spine surgeons who cover. The policy needs to be clearer as to what injuries are admitted vs. transferred. The mortality review should have had more detail. It was unclear why this female died as she did well at home for 4 days with this injury before presenting. There was no mention of looking at possible overmedication as a potential cause for her respiratory decompensation.</p>		
Applicable Standard - If the Reviewer Comments are pertinent to a non-compliant standard, include the applicable standard(s).		

Case Review Template

CASE # 15

Injury Category	GCS	ISS
Mortality without OFI	15	9
Narrative - Include a brief overall summary of the case, detailing the scope of the patient's care from injury to discharge.		
<p>An elderly male with hypertension, diabetes, CHF, and COPD sustained a same level fall. EMS documented stable vital signs. There was a second level trauma activation. The patient was diagnosed with a hip fracture, and he was admitted to the hospitalist with orthopaedic surgery consulting. He went for ORIF the following day. He was ordered aspirin for VTE prophylaxis. On POD #7, he was transferred to the ICU for worsening respiratory failure and fever. The patient had pre-existing DNR/DNI and Palliative care was consulted. He had AKI and the family wanted to attempt dialysis which was not tolerated. He was then made CMO and expired after a 10-day hospital stay.</p>		
PI Summary - Include a summary of all performance improvement measures taken by the program in response to the case, including all corrective action and loop closure.		
<p>This case was reviewed from primary to tertiary level. The nonsurgical admission was considered appropriate. The orthopaedic surgery was 24 hours and 27 minutes after arrival so was not in compliance with policy. Unplanned ICU admit was trended, and in terms of his AKI, it was determined that he had undiagnosed chronic renal disease. Based on age and comorbidities, no OFI was identified.</p>		
Reviewer Comments - Include a statement discussing appropriateness of care.		
<p>Overall the PI was good. As with other cases, EMS does not place cervical collars on elderly same level fall patients. The trauma surgeons claim to see all isolated hip fracture patients, but the "brief consult" notes fail to document a physical exam.</p>		
Applicable Standard - If the Reviewer Comments are pertinent to a non-compliant standard, include the applicable standard(s).		

Case Review Template

CASE # 16

Injury Category	GCS	ISS
MTP	11	11
Narrative - <i>Include a brief overall summary of the case, detailing the scope of the patient's care from injury to discharge.</i>		
A 50-year-old intoxicated male was assaulted and he presented by private vehicle. He was initially a Level II activation which was upgraded to a Level I. The trauma surgeon response was 30 minutes. Initial vital signs were BP 71/44, P56, oxygen saturation 99%. FAST was negative. He had a lactate of 7.2. MTP was activated and terminated after 4 units PRBC. Injuries identified were open bimalleolar ankle fracture, nasal fracture, tongue laceration, and scalp contusion. He received timely antibiotics and his ankle was irrigated and splinted. He was transferred to the Level I trauma center 3 hours and 15 minutes after arrival.		
PI Summary - <i>Include a summary of all performance improvement measures taken by the program in response to the case, including all corrective action and loop closure.</i>		
Primary through tertiary review was done. Antibiotics were < 60 minutes. MTP was activated then terminated. The ED Liaison addressed balanced resuscitation with the ED providers. Belmont education for nursing staff occurred at their skills fair. The transfer was considered appropriate.		
Reviewer Comments - <i>Include a statement discussing appropriateness of care.</i>		
The reason for transfer was not documented. This reviewer presumed it was for the orthopaedic injury, but the TPM stated it was trauma surgeon decision due to unclear source of blood loss. The PI minutes should have been clearer. He had stabilized after 4 units PRBC, so it seems that this patient could have stayed at this facility.		
Applicable Standard - <i>If the Reviewer Comments are pertinent to a non-compliant standard, include the applicable standard(s).</i>		

Case Review Template

CASE # 17

Injury Category	GCS	ISS
Nonsurgical admission with ISS>9	11	10
Narrative - <i>Include a brief overall summary of the case, detailing the scope of the patient's care from injury to discharge.</i>		
<p>A 28-year-old male was the intoxicated, restrained driver of a car that went over a 10-foot embankment and struck a tree. EMS noted stable vital signs, GCS 10, a "rigid abdomen" with a seatbelt sign, and they placed a pelvic binder for concerns of a fracture. There was no documentation that he had a cervical collar placed. On arrival to the ED, he was a Level II activation which was upgraded to a Level I. Initial vital signs were BP 161/89, P94, R29, oxygen saturation 99%. He did not have any films done. FAST was positive, and he was taken for CT scans approximately 1 hour after arrival. MTP had been activated prior to arrival then canceled. The abdominal CT showed free fluid and concern for a bladder injury. The trauma surgeon wrote a note and stated consider transfer. GU was consulted and recommended a CT cystogram which was done < 2 hours after arrival and this confirmed an intraperitoneal bladder rupture. He was admitted to the ICU, on the hospitalist service, after an ED length of stay of 6.5 hours. He was taken to the OR > 24 hours after arrival by GU for exploratory laparotomy and bladder repair. There was no mention of exploration of the rest of the abdomen. The patient had an uneventful hospital stay and was discharged home with a foley catheter on POD #4. SBIRT screen was reportedly negative on this patient. He did not receive chemical VTE prophylaxis during his hospital stay.</p>		
PI Summary - <i>Include a summary of all performance improvement measures taken by the program in response to the case, including all corrective action and loop closure.</i>		
<p>This case was reviewed from primary to tertiary level. It was deemed appropriate for the upgrade and nonsurgical admission even though Nelson score 2 is consistent with inappropriate NSA. Prolonged ED length of stay was attributed to additional imaging and deemed without OFI.</p>		
Reviewer Comments - <i>Include a statement discussing appropriateness of care.</i>		
<p>There were numerous concerns about the care of this patient which were discussed in detail with the TPM:</p> <ol style="list-style-type: none"> 1. No cervical collar in an intoxicated patient with a high mechanism of injury. 2. No initial imaging in the ED, violating ATLS principles, especially since EMS had concerns for an unstable pelvic fracture. 3. The prolonged ED length of stay was falsely attributed to waiting for the CT cystogram. This reviewer looked at the images and the diagnosis was clear, and the study was done within 2 hours of his arrival. 4. Most importantly, the nonsurgical admission was inappropriate. The trauma surgeon considered transfer but then abdicated all responsibility for the patient. A young patient with a severe mechanism should not be admitted to the hospitalist service. 5. Delay to OR was never addressed. Given his CT findings of hemoperitoneum and abdominal tenderness with a seatbelt sign, this patient could have easily had a blunt bowel injury. The GU operative note described a limited exploration to repair the bladder only and this was done > 24 hours after arrival. 6. This patient reportedly had a negative CAGE screen, yet he had a positive blood alcohol level and was driving while intoxicated. This highlighted a flaw in their screening process. 7. There was no chemical VTE prophylaxis, violating their policy, which seems due to the fact that the trauma surgeon did not take responsibility for this patient. 		
Applicable Standard - <i>If the Reviewer Comments are pertinent to a non-compliant standard, include the applicable standard(s).</i>		
7.3 [OFI]		

Case Review Template

CASE # 18

Injury Category	GCS	ISS
Ortho- open fracture	15	9
<p>Narrative - Include a brief overall summary of the case, detailing the scope of the patient's care from injury to discharge.</p> <p>A 77-year-old female sustained a ground level fall. EMS noted a blood sugar of 43 and treated her with D50. Her GCS went from 11 to 15 prehospital. On arrival to the ED as a Level II activation, she had vital signs: BP 137/60, P66, R17, T98.6, oxygen saturation 99%. CXR was done shortly after arrival and then she went for CT scans. Injuries were an open bimalleolar ankle fracture. She was admitted to the hospitalist service and ortho was consulted. She received antibiotics in a timely manner and was taken to the OR the following day. On POD #4, she went into rapid atrial fibrillation for which an RRT was called, and she was transferred to the ICU. Cardiology was consulted and recommended Eliquis. She spontaneously converted to normal sinus rhythm the following day. She was discharged home after a 9-day hospital stay on twice a day aspirin.</p>		
<p>PI Summary - Include a summary of all performance improvement measures taken by the program in response to the case, including all corrective action and loop closure.</p> <p>Primary to tertiary review was done. Antibiotics and operative intervention were within policy parameters. Nonsurgical admission was considered appropriate and the unplanned ICU admission was reviewed but no OFI was identified.</p>		
<p>Reviewer Comments - Include a statement discussing appropriateness of care.</p> <p>There was no cervical collar by EMS, a frequent occurrence based on chart reviews. Overall, care and PI were appropriate. There was a trauma "brief consult" on the chart on hospital day #2 without documentation of a physical exam, so based on documentation, it is not clear that the trauma surgeon is fully evaluating these isolated orthopaedic patients.</p>		
<p>Applicable Standard - If the Reviewer Comments are pertinent to a non-compliant standard, include the applicable standard(s).</p>		

Case Review Template

CASE # 19

Injury Category	GCS	ISS
Ortho- open fracture	15	9
Narrative - Include a brief overall summary of the case, detailing the scope of the patient's care from injury to discharge.		
A 36-year-old male was pinned by a forklift to his leg. EMS and ED vital signs were stable. No trauma activation occurred. He was admitted to the hospitalist service with orthopaedic surgery consulted for an open tibia fracture. The injury was irrigated and splinted in the ED, and he was taken for ORIF the following day. VTE prophylaxis consisted of aspirin, 325 mg daily starting on POD #1.		
PI Summary - Include a summary of all performance improvement measures taken by the program in response to the case, including all corrective action and loop closure.		
This case was reviewed at primary and secondary levels. Antibiotics and OR timing were within policy parameters. The nonsurgical admission was deemed appropriate.		
Reviewer Comments - Include a statement discussing appropriateness of care.		
Care and PI were acceptable. There is no consistency regarding VTE prophylaxis for the isolated orthopaedic injury.		
Applicable Standard - If the Reviewer Comments are pertinent to a non-compliant standard, include the applicable standard(s).		

Case Review Template

CASE # 20

Injury Category	GCS	ISS
Transfer	15	5
<p>Narrative - Include a brief overall summary of the case, detailing the scope of the patient's care from injury to discharge.</p> <p>A 78-year-old female on Coumadin sustained a same level fall. She presented to the ED by private vehicle and was activated as a Level II trauma. Initial vital signs were BP 153/67, P50, R16. No imaging was done in the ED, and she went for head/neck CT within 15 minutes. Injuries identified were C4 fracture, vertebral artery injury (based on follow-up CTA), and a forehead laceration. She was transferred out after an ED LOS of close to 6 hours.</p>		
<p>PI Summary - Include a summary of all performance improvement measures taken by the program in response to the case, including all corrective action and loop closure.</p> <p>Primary and secondary reviews were done. She had regular CT orders, not flagged as trauma which led to a delay in the reads and thus led to a delay in the transfer. She was transferred to the Level I trauma center without a cervical collar despite the C4 fracture being identified. Her care was shared by 2 ED physicians, and their care was tracked for a while by the PI program without further issue. One admitted fault, the other provider is no longer at this facility.</p>		
<p>Reviewer Comments - Include a statement discussing appropriateness of care.</p> <p>PI for this patient was acceptable. Presumably the reason for transfer was the BCVI.</p>		
<p>Applicable Standard - If the Reviewer Comments are pertinent to a non-compliant standard, include the applicable standard(s).</p>		