Pre-Review Questionnaire (PRQ) Frequently Asked Questions

1. **Can abbreviations be used on the Pre-Review Questionnaire?**

   Do not use abbreviations on the Pre-Review Questionnaire because abbreviations may not be the same from trauma care facility to trauma care facility. Write out all words and examples.

2. **For the type of visit (question # 1 on the Pre-Review Questionnaire and Application Checklist form, DPH 7484), do I mark first visit or renewal visit?**

   Mark the first visit this time. This is the first site visit made by the State of Wisconsin to your trauma care facility. The site visit means the actual physical site visit to your hospital. Filling out the assessment criteria document does not count as a site visit. The renewal box will be marked on your second site visit which will not start until at least 2010. This document is made so that the state does not have to create another Pre-Review Questionnaire document for future site visits. The renewal box can be checked and new information added or updated.

3. **What are injury prevention initiatives and/or programs?**

   Injuries cause death and disability. Strategies that decrease or prevent injury can improve the health of the community. Injury prevention initiatives and/or strategies focus primarily on environmental design, product design, human behavior, education, and legislative and regulatory requirements that support environmental and behavioral change (*Center for Disease Control*).

   Examples can include, but are not limited to: car seat clinics, bike helmet clinics, burn safety camp, farm safety, teen alcohol prevention programs (ENCARE, PARTY, Every 15 Minutes, etc…), ATV safety, hunting safety, snowmobiling safety, boating safety, poison control prevention, seat belt safety, etc… There are so many great national, state, and/or local programs to utilize or you can develop your own.

4. **What is the difference between the Trauma Service and the performance improvement process (question #6)?**

   A "Trauma Service" represents a structure of care for the injured patient. The Trauma Service includes personnel and other resources necessary to ensure appropriate and efficient delivery of care through a multidisciplinary continuum. The Trauma Service encompasses all the roles in your trauma program and how your Trauma Care Facility manages trauma on a day to day basis. This will include the day to day care by the Trauma Coordinator or trauma team, trauma performance improvement, etc. The precise nature of the Trauma Service will differ from Trauma Care Facility to Trauma Care Facility and is based on the needs of the medical facility, available personnel, and quantity of resources. This may include a method to identify patients, monitoring the provision of care, or holding formal and informal discussions with individual practitioners (*ACS Resources for the Optimal Care of the Injured Patient:1999*) . This can include but is not limited to performance improvement. The explanation of how

issues are handled in your Trauma Service can be different than the trauma performance improvement process. How are issues found? How do they get brought forward? How are they corrected? For example, a trauma issue may be brought to the Trauma Coordinator, such as an equipment problem. The Trauma Coordinator may be able to solve the problem without having to take it to the multidisciplinary performance review committee. Issues can be brought forward for full review as well.

5. What is the Injury Severity Score?

It is difficult to explain the Injury Severity Score without the Abbreviated Injury Scale. The following contains basic information about both scales. The Abbreviated Injury Scale (AIS) ranks traumatic injuries in terms of the anatomical location and severity of the injury. Each traumatic injury is assigned a 7 digit number, with the last number representing severity of the injury to be used in tabulating the Injury Severity Score (ISS). AIS numbers can be found in the Abbreviated Injury Scale Dictionary distributed by the Association for the Advancement of Automotive Medicine. An AIS code example: Brain Stem Contusion 140204.5

The Injury Severity Score (ISS) is also an anatomical scoring system, but only recognizes the highest Abbreviated Injury Scale in each of the six body regions (head, face, chest, abdomen, extremities, and external). The ISS is used to assess survivability and often compared with benchmarks in areas as ISS vs. length of stay, ISS and mortality, etc. **Only the highest AIS score in each body region is used, the three most severely injured body regions have their scores squared and added together to produce the ISS.**

Example:

Injury	Injury Description	AIS	Square Top Three
Head & Neck	Small epidural hematoma Brain Stem Contusion	4 5	 25
Face	Closed nasal fracture	1	
Chest	Bilateral Pulmonary Contusions	4	16
Abdomen	Grade II Liver Contusion Grade III Kidney Laceration	2 3	 9
Extremity	No Injury	0	
External	No Injury	0	
		Injury Severity Score	50

An ISS score ranges from 0 to 75, any un-survivable injury is assigned an AIS of 6, which will automatically assign a score of 75.

6. Do surgeon response times have to be documented?

Yes, all surgeon response times must be documented. This includes the time the surgeon was paged or called and the time of physical response in the department. You need both times to calculate the response time.

7. How can a Trauma Care Facility track surgeon response times?

There are several ways to track surgeon response times. Each Trauma Care Facility will decide how to document the response times: time of page or call and time of physical response. Some options may be a box on the trauma flow sheet to write down the appropriate times of surgeon response, a response log book in which times can be documented or signed in by staff or the surgeon, or a computer spread sheet. Some Trauma Care Facilities like to have the surgeon sign in on a board by the trauma room and this is documented on the chart appropriately. It is not recommended to have response times just written in the narrative. It is difficult to locate and requires more time for the staff person monitoring this data. This type of system can also be utilized for Operating Room staff, Radiology staff, etc. who also need documented response times.

8. Does a Trauma Care Facility need a diversion protocol if they do not divert major trauma patients?

Yes, all Trauma Care Facilities need a diversion document. There may be a time when the Trauma Care Facility needs to divert major trauma patients. It could be for power failure, natural disaster, etc. Events occur that are out of the control of the Trauma Care Facility that do not allow them to care for some or any major trauma patients. There may be times when the Trauma Care Facility may be in a disaster environment and may need to divert and utilize other resources. It is always best to prepare for the worst and have a diversion protocol and a back up plan with resources ready.

9. When can I check not applicable on the Pre-Review Questionnaire?

A Trauma Care Facility can check “not applicable” on the Pre-Review Questionnaire when they do not have the service or department. For example, if a Level IV Trauma Care Facility does not have an operating room, the facility would check “not applicable”. If a Level IV Trauma Care Facility has an ICU, Radiology Department or an operating room, the facility must check all that apply.