Department of Health
Division of Emergency Preparedness and Community Support
Bureau of Emergency Medical Oversight
Trauma Program
Site Survey Evaluation for Hospital Staff

We would greatly appreciate your response to this questionnaire. Your input is instrumental in the continued development of Florida's trauma center verification process. While simple yes/no responses may directly answer the questions, comments will further assist our efforts to improve the process. All responses will be utilized by the Department of Health, Division of Emergency Preparedness and Community Support, to enhance continuous quality improvement, please be direct in your response.

Please send or fax your response to the Department of Health, Division of Emergency Preparedness and Community Support, at your earliest convenience.

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Florida Department of Health
Director, Division of Emergency Preparedness and Community Support
4052 Bald Cypress Way, Bin A-22
Tallahassee, FL 32399-1738
Fax: (850) 414-6470

1. Your facility's level of verification:

☐ Level I ☐ Level II ☐ Pediatric

2. Your position within the trauma center/program:

☐ Administrator ☐ Nurse ☐ Physician

☐ Other (Please specify): _____

3. Name (Optional): _____

Hospital affiliation (Optional): _____

Scheduling/Renewal Process

1. Did Department of Health, Trauma Program, staff consider needs expressed by your facility regarding the survey scheduling or renewal process?
___ Yes ___ No

If no, please comment.

2. Please provide any suggestions you have for improving the survey scheduling process.

3. Did Department of Health, Trauma Program, staff demonstrate knowledge and give accurate information related to the scheduling or renewal process?
___ Yes ___ No

If no, please comment.

Pre-Survey

1. Were pre-survey time frames reasonable? ___ Yes ___ No

If no, please comment.

2. Were Department of Health, Trauma Program, staff responsive and knowledgeable related to your pre-survey questions? ___ Yes ___ No

If no, please comment.

3. Were pre-survey documents and instructions helpful, accurate, complete, and easy to understand? ___ Yes ___ No

If no, please explain, noting the specific document(s) or instruction(s).

Site Survey Visit

1. Was the site survey time schedule appropriate for the purpose of the site survey?
___ Yes ___ No

If no, please comment.

2. Please list any recommendations for additions to or deletions from the site survey time schedule that would enhance the survey, the site surveyors' understanding of your system, or the Department of Health, Trauma Program's ability to review trauma center verification status.

3. Did the members of the medical staff who participated in the physician peer and group meetings find the meetings of value? ___ Yes ___ No

   If no, please indicate what could be included to provide maximum information during that portion of the survey agenda.

Site Surveyors

The site surveyors for your institution were as follows:

OUT-OF-STATE SURVEYORS	DEPARTMENT OF HEALTH STAFF
TRAUMA SURGEON:	
NEUROSURGEON:	
ORTHOPEDIC SURGEON	
EMERGENCY PHYSICIAN:	
REGISTERED NURSE:	

If necessary, please note the specific surveyor(s). Responses will be kept confidential by the Department of Health, Trauma Program.

1. Were the out-of-state site surveyors appropriately matched to your institution based on professional background and qualifications? ___ Yes ___ No

   If no, please comment.

2. Please provide any comments you have regarding the out-of-state surveyors and their completion of the site survey visit; for example, interaction with hospital personnel, accuracy and fairness, and effectiveness in accomplishing the objectives of the site survey.

3. Please provide any comments you have regarding the Department of Health, Trauma Program, staff and their completion of site survey visit; for example, interaction with hospital personnel, accuracy and fairness, and effectiveness in accomplishing the objectives of the site survey.

Post Site Survey

1. Was the written survey information/findings accurate and complete?
___ Yes ___ No

   If no, please comment.

2. Were you offered the opportunity to submit additional information subsequent to notification of survey findings? ___ Yes ___ No

   If no, please comment.

3. Were you offered the opportunity to contact Department of Health, Trauma Program staff with questions or concerns related to the written report of survey findings or how to respond? ___ Yes ___ No

   If no, please comment.

4. Please indicate anything the Department of Health; Trauma Program staff could do to increase your understanding of survey requirements and preparation for the site survey.

5. Do you feel confidentiality has been maintained by the Department of Health, Trauma Program staff related to the survey process?
___ Yes ___ No

If no, please comment.

Quality Assurance Activities

1. Did the out-of-state site surveyors and the Department of Health, Trauma Program staff assist you with review of quality assurance monitoring activities with identification of trends, data collection, and program evaluation?
___ Yes ___ No

If no, please comment.

2. Please list any recommendations for additions or deletions to quality assurance activities for the Department of Health, Trauma Program staff.

Overall Effectiveness:

1. Please rate the overall effectiveness of the Department of Health staff to the entire survey process.

Excellent: ☐	Good: ☐	Fair: ☐	Poor: ☐

2. Please rate the overall effectiveness of the trauma center site survey process.

Excellent: ☐	Good: ☐	Fair: ☐	Poor: ☐

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Please use a separate page for additional comments.