
Virginia Office of Emergency Medical Services
Medical Records Required for Site Reviews

Virginia Department of Health
Office of Emergency Medical Services
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Purpose:

The following is an overview of the medical records that are to be available to trauma center designation site review teams during site reviews. The evaluation of medical records by a site review team is essential in evaluating trauma care and the performance improvement (PI) efforts by designated trauma centers.

Electronic Medical Records: if your hospital uses electronic medical records it is your choice how you would like to provide them to the site review team. As long as the team can review the medical records requested by Virginia Department of Health's, Office of Emergency Medical Services (VDH/OEMS), whether they are printed out or the team is given access to them electronically it is your hospital's decision. If you print out the charts, the site review team needs to have the following sections of each medical record:

- Pre-hospital Patient Care Report
- Emergency Department Trauma Flow Sheet
- Emergency Department Physician Documentation (i.e. QualChart)
- Trauma Surgeon's Notes/H&P
- Radiology Reports
- ICU Flow Sheets
- Operative Notes/Surgical Summaries
- Consult Reports (i.e. neurosurg, ortho surg. and other required specialties)
- Discharge Summary

Guidance:

The list of medical records listed below will include records that are typically within an eighteen month time period preceding the site review, unless otherwise specified. The VDH/OEMS or any member of a site review may, at the time of a site review, request additional medical records as needed, but are limited to requesting charts within the current three year verification cycle.

The VDH/OEMS, Trauma/Critical Care Coordinator will provide to the hospital, no less than 14-30 days prior to the scheduled site review, an individualized medical record request to the applying hospital. Specific medical records will be requested using the Virginia Statewide Trauma Registry, the Virginia Pre-Hospital Information Bridge, the hospital's internal registry, or other validated sources.

Medical records to be provided by the applying center in addition to the specific records requested by OEMS:

- All trauma charts from patients that died as a result of their trauma (past 18 months).
- All trauma charts that have gone through your hospital's highest tier PI review process that required corrective action and/or follow up.

Medical records that will be requested by specific medical record number or other identifiers will include the following types:

- Blunt Trauma
 - blunt head
 - blunt thoracic
 - blunt abdominal
 - blunt orthopedic
 - blunt serious other
- Penetrating Trauma
 - penetrating head
 - penetrating thoracic
 - penetrating abdominal
 - Penetrating Serious (i.e. neck, serious extremity)
- Spinal injury
- Vascular
- Burns
- Ophtho/ENT/Face
- Pediatric charts (please include a variety of injury types)
- Death
- Transfers received
- Transfers out
- Rehab charts (if in-house rehab is provided)
- Extended stays in the ICU.
- Re-admissions within 24-48 hours.

Note: OEMS typically request approximately 50 – 60 specific medical records. This estimated number may increase as dictated by the application review or similar factors.