Workgroup Notes 11/10/10 ADVANCED (LEVEL III) TRAUMA FACILITY CRITERIA

Advanced Trauma Facility (Level III) - provides resuscitation, stabilization, and assessment of injury victims and either provides treatment or arranges for appropriate transfer to a higher level designated trauma facility; provides ongoing educational opportunities in trauma related topics for health care professionals and the public; and implements targeted injury prevention programs (see attached standards). The administrative commitment of a Level III trauma facility includes developing processes that define the trauma patient population evaluated by the facility and track them throughout the course of their stay in order to maximize funding opportunities.

A. TRAUMA PROGRAM	
1. There is a defined Trauma Service to include: a. Current Board of Trustee and Medical Staff resolutions supporting the implementation and maintenance of the appropriate level trauma services at the facility. This document is complimented by a signed Medical Staff resolution supporting the job functions of the trauma medical director, trauma program manager and resources to maintain trauma center designation. b. An active membership in the Regional Advisory Council. c. Staff dedicated to the development and maintenance of trauma services to include, but not limited to a trauma medical director, trauma program manager and trauma registrar(s). d. Physicians and hospital staff educated and credentialed for the care of trauma patients. e. Policies and Procedures specific to trauma care in the facility. f. Trauma performance improvement and patient safety processes dedicated to providing quality, accountable trauma care. g. Budgetary support for required components including education, training, equipment and staff to support the program needs. h. Identified executive level (administrative) trauma leadership who has documented education regarding trauma programs, trauma system development and the requirements for trauma center designation to include the CEO, CFO and CNO of the hospital. 2. Trauma Service – a. The trauma service led by the Trauma Medical Director, who has the oversight and authority for trauma care within the facility. b. Trauma Service is compromised of the Trauma Medical Director, core trauma surgeons, trauma program manager, trauma program staff, defined liaisons for orthopedics, neurosurgery (if	E

available), emergency medicine and anesthesiology. c. Patients defined as critical and major trauma will initially be admitted by the trauma service. d. The Trauma Service will define trauma patient standard of care from resuscitation through all phases of care utilizing evidenced based criteria. This includes standards for trauma admissions and trauma transfers. The major or severe trauma patient shall be rapidly assessed, resuscitated, and stabilized according to established trauma management guidelines including ATLS, TNCC, ATCN, and ENPC. e. Disposition decisions shall be made expeditiously by a physician at the hospital and preparations for transfer or admission begun as soon as possible after arrival at the facility. Major or severe trauma patients who are retained longer than 2 hours, except where medically appropriate, shall receive the same level of care as the highest available within its TSA or within the TSA to which the patient's condition warrants transfer-out.	
2. An identified Trauma Medical Director (TMD) who: a. is a general surgeon. b. is currently credentialed in Advanced Trauma Life Support (ATLS) or an equivalent course approved by the Department of State Health Services (DSHS). c. is charged with overall management of the trauma program provided by the hospital. d. shall have the authority and responsibility for the clinical oversight of the trauma program. This is accomplished through mechanisms that include: 1. Recommending trauma team privileges;2.developing treatment protocols; 2. Cooperating with the nursing administration to support the nursing needs of the trauma patients; 3. Oversees the performance improvement (PI) and trauma peer review; 4. Correcting deficiencies in trauma care or excluding from trauma call those trauma team members who do not meet criteria;	E

6. Oversees the budgetary process for the trauma program; 7. Through the PI process have oversight of care on all admitted major or severe trauma patients, 8. Chairing the trauma PI process 9. Oversight of multidisciplinary trauma conferences. 3. The TMD, credentialed by the hospital, shall: a. participate in the resuscitation and treatment of trauma patients b. is actively taking trauma call c. is board certified in general surgery by the American College of Surgeons and has completed a board-approved training program in general surgery or is board-eligible with at least 12 months of experience in providing care to trauma patients. *A non-board certified general surgeon desiring inclusion in a hospital's trauma program shall meet the American College of Surgeons (ACS) guidelines as specified in its most current version of the "Resources For Optimal Care Of the Injured Patient", Alternate Criteria section. d. Has documentation of 16 hours of trauma continuing medical education annually, e. Demonstrates compliance with trauma protocols, and participation in the trauma PI program. f.. There shall be a defined job description and organizational chart delineating the TMD's role, responsibilities and authority to manage the trauma program. g.. The TMD shall have evidence of active participation in the hospital, community, and emergency management (disaster) response to include: 1. Completion of ICS 100 & 200, 2. Participation in mass casualty drills 3. Participate in disaster education. h.. The TMD shall annually review the regional trauma system plan.	
4. An identified /Trauma Program Manager TPM) who: a. Is a registered nurse. b. Has successfully completed and is current in the Trauma Nurse Core Course (TNCC) or Advanced Trauma Course for Nurses (ATCN) or a DSHS-approved equivalent. c. Has successfully completed and is current in a nationally recognized pediatric advanced life support course (e.g. Pediatric Advanced Life Support (PALS) or the Emergency Nurse Pediatric Course (ENPC)).	E

d. Shall have the authority and responsibility to monitor trauma patient care from point of injury through ED resuscitation, operative intervention(s), ICU care, stabilization, all inpatient care, and discharge,

e. Shall have the authority, oversight and responsibility of the trauma PI program, the trauma registry, injury prevention and outreach education.

f . There shall be a defined job description and organizational chart delineating the TPM's role with clearly defined direct reporting to the senior hospital administration and indirect reporting to the Trauma Medical Director.

g. The TPM shall participate in a leadership role in the hospital, community, and regional emergency management (disaster) response to include:

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1. Completion of ICS 100 & 200
2. Participation in mass casualty drills
3. Disaster education

h.. This position shall be full-time with a minimum of 80% of the time dedicated to the management of the Trauma program; with evidence of 80% compliance of concurrent review, trauma registry data extraction, data entry and data completion within 60 days of patient discharge, compliance with RAC participation and participation in injury prevention and outreach education.

i.. The TPM shall complete a course designed for their role which provides essential information on the structure, process, organization and administrative responsibilities of a PI program to include: Trauma Program Manager's Course (TPMC) or Texas Trauma Designation Course (TTDEC) within 12 months of date of hire. Additionally, a trauma outcomes and performance improvement course (e.g. Trauma Outcomes Performance Improvement Course (TOPIC) shall be completed within 12 months of hire.

j. The TPM must have appropriate trauma registry training (e.g. the Association for the Advancement of Automotive (AAAM), American Trauma Society (ATS) Trauma Registrar Course in injury severity scaling or DSHS approved equivalent within 12 months of date of hire.

4. There shall be an identified Trauma Registrar. a. who has appropriate training in injury severity scaling (e.g. the Association for the Advancement of Automotive Medicine (AAAM) course within 12 months of hire; b. Training in data abstraction, data management and trauma program support (e.g. the American Trauma Society (ATS) Trauma Registrar Course)) or DSHS approved equivalent within 12 months of date of hire. c. There shall be a dedicated FTE to the trauma registry which maintains a ratio of 1:500 with demonstrated 80% compliancy of trauma profile completion within 60 days of discharge. d. To perform the duties of the trauma registrar to include the abstract and input of trauma data, submission to the state and completion of the 3588 application. e. This position must be supervised by the Trauma Program Manager.	E
6. Participation in Texas Trauma Coordinator's Forum	D
7. Written protocols, developed with approval of the hospital's multidisciplinary trauma committee, for: a. Trauma team activation that at a minimum shall be compliant with the American College of Surgeons, Optimal Care Resources for the Injured Patient's minimal standards, state, and regional guidelines b. Identification of trauma team responsibilities during a resuscitation. c. Resuscitation and treatment of trauma patients. d. Triage, admission and transfer of trauma patients including the definition of a trauma patient. e. Trauma Patient Standard of Care Guidelines reflecting current evidenced based treatment for all patient populations within the resources and capabilities of the facility. The Guidelines must be available on all units providing care for the trauma patient.	E
8. All major and severe trauma patients shall be admitted to the trauma service and an appropriate surgical service. All major and severe trauma patient shall be defined as: any patient with injuries threatening life or limb, severe pain, or has injuries with potential to impact function or to produce complications resulting in death or disability.	E

B. PHYSICIAN SERVICES	
1. SURGERY DEPARTMENTS/DIVISIONS/SERVICES/SECTIONS	
a. General Surgery	E
1. A general surgeon who is providing trauma coverage shall be currently credentialed in ATLS or an equivalent course approved by DSHS. 2. A general surgeon who is providing trauma coverage shall be credentialed by the TMD to participate in the resuscitation and treatment of trauma patients to include: a. current board certification/eligibility, b. an average of 9 hours of trauma-related continuing medical education per year c. compliance with trauma protocols, and participation in the trauma PI program. d. Additionally the core attending general surgeons that are providing coverage shall attend 50% or greater of multidisciplinary and peer review trauma committee meetings. e. A non-board certified general surgeon desiring inclusion in a hospital's trauma program shall meet the American College of Surgeons (ACS) guidelines as specified in its most current version of the "Resources For Optimal Care Of the Injured Patient", Alternate Criteria section. f. Communication shall be such that the attending general surgeon shall be present in the ED at the time of arrival of the highest level of trauma activation trauma patient; maximum response time of the attending surgeon shall be 30 minutes from trauma team activation. This system shall be continuously monitored by the trauma PI program. g. In hospitals with surgical residency programs, evaluation and treatment may be started by a team of surgeons that shall include a PGY4 or more senior surgical resident who is a member of that hospital's residency program. The attending surgeon must be present within fifteen minutes and oversee decision making in major therapeutic decisions, presence in the emergency department for major resuscitations, and presence at operative procedures are mandatory. Compliance with these criteria and their appropriateness shall be monitored by the trauma PI program. h. When the attending surgeon is not activated initially and it has been determined by the emergency physician that an urgent surgical consult is necessary, maximum response time of the attending surgeon shall be 60 minutes from notification to physical presence at the patient's bedside. This system shall be continuously monitored by the trauma PI program.	E

i. There shall be a published on-call schedule for obtaining general surgery care. j. There shall be a documented system for obtaining general surgical care for situations when the attending general surgeon on-call is unavailable. k. Ideally, the surgeon is on-call only at one institution; otherwise, a published back-up call schedule shall be in place in the emergency department. This system shall be continuously monitored by the trauma PI program. • Midlevel practitioners will not replace the requirement for the surgeon in trauma response.	
b. Orthopaedic Surgery	E
The TMD shall identify an orthopedics representative to the multidisciplinary trauma committee. This orthopedic surgeon representative shall have: 1. An average of 9 hours of orthopedics-trauma related continuing medical education per year. 2. Attend 50% or greater of multidisciplinary and peer review trauma committee meetings; 3. Participate in the resuscitation and treatment of trauma patients; have current board certification/eligibility, *A non-board certified general surgeon desiring inclusion in a hospital's trauma program shall meet the American College of Surgeons (ACS) guidelines as specified in its most current version of the "Resources For Optimal Care Of the Injured Patient", Alternate Criteria section. 4. Compliance with trauma protocols. 5. Participation in the trauma PI program. - An orthopedic surgeon providing trauma coverage shall: a. Be credentialed by the TMD to participate in the resuscitation and treatment of the trauma patient. b. The orthopedic surgeon shall be promptly available (physically present) at the patient's bedside within 30 minutes of request by the attending trauma surgeon or emergency physician from inside or outside hospital for all patients with life or limb threatening injuries. This system shall be continuously monitored by the trauma PI program. c. When the orthopedic surgeon is not activated initially and it has been determined by the emergency physician or trauma surgeon that an urgent orthopedic surgical consult (as defined by	E

the facility) is necessary, maximum response time shall be 60 minutes from notification to physical presence at the patient's bedside. This system shall be continuously monitored by the trauma PI program. d. There shall be a published on-call schedule for obtaining orthopedic surgery care. e. There shall be a documented system for obtaining orthopedic surgery care for situations when the attending orthopedic surgeon on call is unavailable. f. Ideally, the orthopedic surgeon should be on-call only at one institution; otherwise, a published back-up plan shall be in place in the emergency department. This system shall be continuously monitored by the trauma PI program.	
c. **Neurosurgery** *Neurosurgery coverage is desired in a level III, but the performance standards below are "essential" when a Level III has either full-time, routine or limited neurosurgical coverage. 1. The TMD shall identify a neurosurgical representative to the multidisciplinary trauma committee. The neurosurgeon representative to this committee shall be credentialed by the TMD to participate In the resuscitation and treatment of trauma patients to include: a. Board certification/eligibility, *A non-board certified general surgeon desiring inclusion in a hospital's trauma program shall meet the American College of Surgeons (ACS) guidelines as specified in its most current version of the "Resources For Optimal Care Of the Injured Patient", Alternate Criteria section. b. Compliance with trauma protocols c. Participation in the trauma PI program. d. An average of 9 hours of trauma-related continuing medical education per year f. The neurosurgeon representative to the multidisciplinary trauma committee shall attend50% or greater of multidisciplinary and peer review trauma committee meetings. g. A neurosurgeon providing trauma coverage shall be promptly available (physically present) at the major or severe trauma patient's bedside within 30 minutes of an emergency request by the attending trauma surgeon or emergency physician from inside or outside the hospital. This system shall be continuously monitored by the trauma PI program.	D*

h.. When the neurosurgeon is not activated initially or was not consulted as an emergency and it has been determined by the emergency physician or trauma surgeon that an urgent neurosurgical consult is necessary, maximum response time of the neurosurgeon surgeon shall be 60 minutes from notification to physical presence at the patient's bedside. This system shall be continuously monitored by the trauma PI program. i. There shall be a published on-call schedule for obtaining neurosurgical care. j. There shall be a documented system for obtaining neurosurgical care for situations when neurosurgeon on-call is not available. k. Ideally, the neurosurgeon is on-call only at one institution; otherwise, a published back-upplan shall be in place in the emergency department. This system shall be continuously monitored by the trauma PI program.	
d. Ophthalmic Surgery	D
e. Otorhinolaryngologic or Maxiofacial Surgery	D
f. Thoracic Surgery	D
g. Urologic Surgery	D
2. NON-SURGICAL SPECIALTIES AVAILABILITY	

a. **Emergency Medicine** - this requirement shall be fulfilled by a physician credentialed by the hospital 1. To provide emergency medical services. 2. In-house 24 hours a day. 3. An Emergency Medicine board-certified physician who is providing trauma coverage shall have successfully completed an ATLS Student Course or a DSHS-approved ATLS equivalent course. Current certification is preferred, however. 4. Current ATLS verification is required for all physicians who work in the emergency department and are not board certified in Emergency Medicine. 5. Any emergency physician who is providing trauma coverage shall be credentialed by the TMD to participate in the resuscitation and treatment of trauma patients of all ages to include: a. have current board certification/eligibility, b. compliance with trauma protocols, and c. participates in the trauma PI program *A non-board certified emergency medicine physician desiring inclusion in a hospital's trauma program shall be: 1. current in ATLS 2. have an average of 9 hours of trauma related continuing medical education annually a (1). The TMD shall identify an emergency medicine physician representative to the multidisciplinary trauma committee. This representative shall: 1. have current board certification/eligibility, (*A non-board certified emergency medicine physician identified by the TMD to be the emergency medicine representative in a hospital's trauma program shall be: a. current in ATLS b. have an average of 9 hours of trauma related continuing medical education annually.) 2. have an average of 9 hours trauma related continuing medical education 3. attend 50% or greater of multidisciplinary and peer review trauma committee meetings 4. have current ATLS certification.	E
d. Current ATLS certification for all physicians taking care of trauma patients is preferred.	D

e. The Emergency Department Medical Director shall have evidence of active participation in the hospital, community, and emergency management (disaster) response to include: 1. completion of ICS 100 & 200, 2. Participation in mass casualty drills 3. participate in disaster education.	E
b. **Radiology** - On-call and promptly available within 30 minutes of request from inside or outside the hospital. The use of teleradiology may fulfill this requirement. Reading turnaround times must be monitored in the trauma PI program. When the physical presence of the radiologist is required, the response time will be no more than 30 minutes. This system shall be continuously monitored by the trauma PI program.	E
c. **Anesthesiology** – this requirement may be filled by a physician credentialed by the hospital to: 1. Participate in the care of the trauma patient 2. On-call and promptly available within 30 minutes of request from inside or outside the hospital. This system shall be continuously monitored by the trauma PI program. 3. Have current board certification by the American College of Anesthesiology or be board eligible. d. (1) The TMD shall identify an anesthesiology representative to the multidisciplinary trauma committee. The anesthesiology representative or designee to this committee shall be credentialed by the TMD to include: 1. shall attend 50% or greater of multidisciplinary and peer review trauma committee meetings.	E
e. **Cardiology**	D
f. **Hematology**	D
g. **Nephrology**	D
h. **Pathology**	D
i. **Pediatrics** - The patient's primary care physician should be notified at an appropriate time.	D
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C. NURSING SERVICES (for all Critical Care and Patient Care Areas)	
1. All nurses caring for trauma patients throughout the continuum of care have ongoing documented	E

knowledge and skill in trauma nursing for patients of all ages to include trauma specific orientation, annual clinical competencies, and continuing education.	
2. .	E
3.	E
3. A written plan, developed by the hospital, for acquisition of additional staff on a 24 hour basis to support units with increased patient acuity, multiple emergency procedures and admissions (i.e. written disaster plan.)	E
5.	D

D. PATIENT CARE AREAS/UNITS	
1. EMERGENCY DEPARTMENT	
a. Designated physician director. b. The EDMD shall have evidence of active participation in the hospital, community, and emergency management (disaster) response to include things such as: 1. completion of ICS 100 & 200, 2. Participation in mass casualty drills 3. participate in disaster education.	E
c. Physician with special competence in the care of critically injured patients, who is a designated member of the trauma team and physically present in the emergency department (ED) 24 hours per day.* *Neither a hospital's telemedical capabilities nor the physical presence of mid level providers shall satisfy this requirement. Additionally, mid-level providers and telemedicine-support physicians who participate in the care of major/severe trauma patients shall be credentialed by the hospital to participate in the resuscitation and treatment of trauma patients, to include: 1. board certification/eligibility, 2. an average of 9 hours of trauma-related continuing medical education per year, 3. compliance with trauma protocols 4. participation in the trauma performance improvement program. 5. All mid level providers participating in trauma resuscitation shall have current ATLS certification.	E

d. The trauma team shall be activated on pre-hospital communication with the ED. The emergency department must have processes in place to emergently assess severe and major trauma patients and ensure immediate appropriate activation of the trauma team with in-house response times not to exceed 15 minutes including patients arriving by private vehicle. (this criterion shall be monitored in the trauma PI program.)	E
e. A minimum of two registered nurses who have trauma nursing training shall participate in initial major and severe trauma resuscitation. Both nurses must be current in ACLS, PALS or ENPC and TNCC or ATCN or a DSHS approved equivalent.	E
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f. *A free-standing children's facility is exempt from the ACLS requirement.	E
g. Nursing documentation for severe and major trauma patients is on a trauma flow sheet, may be electronic or paper , defines the sequence of care, primary and secondary survey with interventions, outcomes, serial vital signs, GCS and coponents of the RTS, consulting services assessment and plan of care with disposition meets the trauma registry guidelines and documents the response time of all trauma team members. .	E
h. 100% of nursing staff caring for the major and severe trauma patients have successfully completed and hold current credentials in an advanced cardiac life support course (e.g. ACLS or hospital equivalent), a nationally recognized pediatric advanced life support course (e.g. PALS or ENPC) and TNCC or ATCN or a DSHS-approved equivalent, within 12 months of date of employment in the ED or date of designation ** **Requirements for a free-standing children's facility: 100% of nursing staff who care for trauma patients have successfully completed and hold current credentials in ENPC or in a nationally recognized pediatric advanced life support course and TNCC or ATCN or a DSHS-approved equivalent, within 12 months of date of employment in the ED. If LVNs are staffed in the ED and participating in trauma resuscitation, 100% of the core LVN ED staff shall audit TNCC; audit ENPC or certify in PALS; hold current certifications in ACLS within 12 months of employment or within 12 months of initial designation. *A free-standing children's facility is exempt from the ACLS requirement.	E
i. Two-way communication with all pre-hospital emergency medical services vehicles.	E

j. Equipment and services for the evaluation and resuscitation of, and to provide life support for, critically or seriously injured patients of all ages shall include but not be limited to:	E
1) Airway control and ventilation equipment including laryngoscope, endotracheal tubes of all sizes, supraglottic airway management devices of all sizes, bag-valve-mask devices (BVMs), pocket masks, oxygen	E
2) Mechanical ventilator	E
3) Pulse oximetry	E
4) Suction devices	E
5) Electrocardiograph-oscilloscope-defibrillator	E
6) Internal age-specific paddles available	E
7) All standard intravenous fluids and administration devices, including large-bore intravenous catheters, a rapid infuser system, intraosseous insertion capability.	E
8) Sterile surgical sets for procedures standard for emergency room including: thoracostomy, venous cutdown, central line insertion, thoracotomy, airway control/cricothyrotomy, etc.	E
9) Diagnostic peritoneal lavage	D
10) FAST capability	D
12) Drugs and supplies necessary for emergency care	E
13) Cervical spine stabilization device	E
14) Length-based body weight & tracheal tube size evaluation system (such as Broselow tape) and resuscitation medications and equipment that are dose-appropriate for all ages	E
15) Long bone stabilization device for all ages.	E
16) Pelvic stabilization device	E
17) Thermal control equipment for patients and a rapid warming device for blood and fluids	E
18) Non-invasive continuous blood pressure monitoring devices	E

19) CO_2 detection device	E
k. Imaging Services.	E
1) In-house technician 24-hours a day or on-call and promptly available within 30 minutes of request. This system shall be continuously monitored by the trauma PI program.	E
l. Psychosocial Support Services - These services shall be available (e.g. chaplain).	E
2. OPERATING SUITE	
a. Operating room services - shall be available 24 hours a day. With advanced notice, the Operating Room should be opened and ready to accept a patient within 30 minutes. This system shall be continuously monitored by the trauma PI program.	E
b. Equipment - special requirements shall include but not be limited to:	E
1) Thermal control equipment for patient and for blood and fluids	E
2) Imaging capability including c-arm image intensifier with technologist available 24 hours a day	E
3) Endoscopes, all varieties, and bronchoscope	E
4) Equipment for long bone and pelvic stabilization	E
5) Rapid infuser system	E
6) Age Appropriate monitoring and resuscitation equipment	E
7) The capability for measuring hemodynamic pressures.	E
8)	
3. POST-ANESTHESIA CARE UNIT (surgical intensive care unit is acceptable)	
a. Registered nurses and other essential personnel 24 hours a day.	E
b. Age appropriate monitoring and resuscitation equipment.	E
c. Pulse oximetry.	E
d. Thermal control equipment for patients and a rapid warming device for blood and fluids.	E
e. End tidal CO2 device	E

4. INTENSIVE CARE CAPABILITY	
a The trauma surgeon must remain responsible for directing the care of trauma patients while in the ICU or until trauma injuries are addressed. b. The TMD shall have authority and oversight of all trauma patients throughout continuum of care.	E E
c. There must be a process in place to ensure prompt availability of ICU physician coverage 24 hours a day. Arrangements for 24-hour surgical coverage of all trauma patients shall be provided for emergencies and routine care. This system shall be continuously monitored by the trauma PI program.	E
d. Registered Nurse-patient minimum ratio of 1:2 on each shift for patients identified as critical acuity.	E
e. Age appropriate monitoring and resuscitation equipment.	E
f. Thermal control equipment for patients and a rapid warming device for blood and fluids available.	E
g. The capability for monitoring hemodynamics.	E
h. ICU Nursing education requirements include: 1. Any nurse taking care of trauma patients in the ED shall have the same education and certifications as the emergency department nurses. 2. There is documented evidence of orientation related to the critical care phase of management of the trauma patient. 3. There is documented evidence of annual competencies in the critical care phase of management of the trauma patient.	E
E. CLINICAL SUPPORT SERVICES	
1. RESPIRATORY SERVICES	
a. In-house and available 24 hours per day.	E
2. CLINICAL LABORATORY SERVICE	

b. Call-back process for trauma activations available within 30 minutes. There shall be documented evidence that this system is continuously monitored in the trauma PI program	
c. Services available 24 hours per day.	E
d.. Standard analyses of blood, urine, and other body fluids, including micro sampling.	E
e. Blood typing and cross-matching with policies to include massive transfusion and emergency release of blood.	E
f. Comprehensive blood bank or access to a community central blood bank and adequate hospital storage facilities. A plan should exist for the procurement of additional blood products as necessary.	E
g. Coagulation studies including PT/PTT and INR	E
h. Blood gases and pH determinations.	E
g. Microbiology.	E
i. Drug and alcohol screening.	E
j Serum and urine osmolality.	D
3. IMAGING CAPABILITIES	
a. Sonography.	E
b. Computerized tomography.	E
c. In-house CT technician 24-hours per day or on-call and promptly available within 30 minutes of request. This system shall be continuously monitored by the trauma PI program.	E
d. Angiography of all types.	D
e. Nuclear scanning.	D
F. SPECIALIZED CAPABILITIES/SERVICES/UNITS	
1. ACUTE HEMODIALYSIS CAPABILITY	
Transfer agreement if no capability.	E
2. ORGANIZED BURN CARE	
Established criteria for care of a burn patient based on the current accepted standards of care and a	E

process to expedite the transfer of a major or severe burn patient to a verified burn center based on the current Burn Center Referral Criteria. Transfer of major/severe burn patients to non-verified burn centers must be reviewed by Trauma PI.	
3. REHABILITATION MANAGEMENT CAPABILITY	
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	E
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2. Physical Medicine and Rehab services	
1. Physical therapy.	E
2. Occupational therapy.	E
3 Speech therapy.	E
4. Established criteria for the treatment and care of a spinal cord/head injury patient based on the current accepted standards of care and a process in place to expedite the transfer to an appropriate rehabilitative facility.	E
a. Social Services/Case Management E	
G. PERFORMANCE IMPROVEMENT	
The Trauma Service shall develop a written trauma performance improvement plan that defines the process of review, the variances, standard of care, elements to review, levels of review, action plans, and loop closure.	E

1. PI History: On Initial Designation: a facility must have completed at least six months of performance improvement review on all qualifying trauma records with evidence of "loop closure" on identified issues. Compliance with internal trauma policies must be evident. On Re-designation: a facility must show continuous PI activities throughout its designation and a rolling current three year history must be available for review at all times.	
2. The trauma program must have authority, oversight and accountability for the trauma performance improvement process. The Minimal Inclusion Criteria for PI: a. All trauma team activations (including those discharged from the ED), b. All trauma deaths or dead on arrivals (DOAs), c. ED-OR trauma admissions, d. ED-ICU trauma admissions or observations; e. all trauma admissions; transfers-in that meet NTDB criteria. f. transfers-out; g. readmissions within 48 hours after discharge. h. all trauma patients that are within the current accepted ICD codes.	E
3. An organized trauma PI program established by the Trauma Program and supported by the hospital, to include special population's specific components,facility specific trauma indicators and indicators included in, but not limited to the Texas EMS Trauma System Performance Improvement Plan.	E
a. Audit and concurrent review of trauma charts for appropriateness and quality of care. Concurrent review of the admitted major/severe trauma patient is a review that occurs within patient's hospital admission. There will be documented evidence of 80% compliancy. Initial reviews and follow up actions must have documented dates to ensure concurrent reviews.	E
b. Severe hemodynamically unstable trauma patients will have documented review to identify compliance to trauma team activation, appropriate response times, timeliness of care, and coordination of care and evidence of compliance to national standards of care. Disposition of this patient population must occur within 2 hours of arrival to the facility.	E
c. Documentation of actions taken to address all identified issues.	E
d. Documented evidence of participation and critical review by the TMD as indicated.	E

e. Documentation of the morbidity and mortality review by the TMD and TPM (or designees) that includes the judgment and action plan defined by the Trauma Service. Special audit by the TPM and the TMD for all trauma deaths and other specified cases, including complications and utilizing age-specific criteria. The TPM and the TMD must be present at all trauma related peer reviews.	E
f. Documented resolutions or "loop closure" of all identified issues to prevent future recurrences.	E
g.	E
h.	E
4. Multidisciplinary hospital trauma committee held no less than quarterly for PI activities a. Statistical Review including volume, ED length of stay, severity of injury, trauma diversion and trauma center criteria compliancy and trauma standards of care. b. System Issues c. Updates on regional and state activities; and disaster preparedness. d. Select case reviews and select complications.	E
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5. Feedback regarding trauma patients transferred in from EDs and inpatient units that are admitted to the facility shall be provided to all transferring facilities.	E
6. Trauma registry data shall be forwarded to the state and regional trauma registry on at least a quarterly basis. There must be documented evidence that the trauma center is completing quarterly downloads within 30 days of the end of the previous quarter.	E
7. Submission to the National Trauma Data Bank.	D
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8. Times of and reasons for diversion must be documented and reviewed by the trauma PI program. Documentation of the following must be included: a. Transfer out denials b. Transfer in denials c. Requests for trauma diversion bypass d. Trauma diversion times of > 5% shall be reported and reviewed by administration and RAC.	E

9. Published on-call schedule must be maintained for general surgeons, orthopaedic and neurosurgeons if available. Surgeons, anesthesia, radiology, and other major specialists if available. Compliance with on-call coverage for essential services shall be monitored in the Trauma PI Process.	E
10. Performance improvement personnel - dedicated to and specific for the trauma program to ensure the maintenance of concurrent review. Concurrent reviews are defined as: Concurrent review of the admitted major/severe trauma patient is a review that occurs within the patient's hospital admission.	E
H. REGIONAL TRAUMA SYSTEM	
Must participate in the regional trauma system per RAC requirements and shall include: 1. Participation with the regional advisory council's PI program. 2. Adherence to regional protocols 3. Review of pre-hospital trauma care 4. Submitting data to the RAC as requested including such things as summaries of transfer denials and transfers to hospitals outside of the RAC. 5. Notification of the regional healthcare community when a usually provided service, either essential or desired is not available. 6. A Level III trauma facility shall present its special population capabilities to the RAC so that both EMS providers and other hospitals can determine the most appropriate facility to transport or transfer critically injured special population patients.	E
I. TRANSFERS	
1. A process to expedite the transfer of applicable major and severe trauma patients to include such things as written protocols , and a transfer plan for patients needing higher level of care or specialty services.	E
2. Disposition decisions shall be made expeditiously by a physician at the hospital and preparations For transfer are begun as soon as possible after arrival at the facility not to exceed > 2 hours.	
3. A system for establishing an appropriate landing zone in close proximity to the hospital (if rotor wing services are available.)	E

4. A log of all trauma transferring denials shall be maintained, reviewed through the facility's trauma performance improvement (PI) process, and referred to the appropriate RAC's systems PI process.	E
5. A Level III trauma facility shall have an established relationship with tertiary trauma facility (ies) to which it transfers patients and with all designated Level IV trauma facilities that regularly initiate transfers-in, to include such things as: written transfer agreements ▪ prospective dialogue regarding appropriate pre-transfer diagnostic laboratory and radiological studies so that each is cognizant of the other's performance expectations ▪ consideration of a single phone call transfer-request process ▪ provision of feedback regarding transfers as part of the PI program	E
J. EDUCATIONAL PROGRAMS	
1. Provide education to and consultations with health care professionals of the community and outlying areas regarding care and treatment of trauma patients. Participation in the regional (RAC) educational programs.	E
2. Provide trauma education to the region based on needs identified in the performance improvement program such as TNCC,	E
K. PUBLIC EDUCATION/INJURY PREVENTION	
The Trauma Program coordinates a public education program to address the major injury problems within the hospital's service area supported by the trauma registry data. Documented participation in a RAC injury prevention program is acceptable.	E
. 1. There shall be documentation that the TPM has education in Injury Prevention	.D
	E

L. ADMINISTRATION	
1. Evidence of participation in trauma center education specifically targeting the administrator, chief executive officer	E
2. Establishes a process to utilize UB 94 or managed care carve out for trauma charges.	E
3. Establishes a process to develop a budget line for trauma.	E
4. Establishes a process to demonstrate that the uncompensated care reimbursement to the facility through the Driver Responsibility Program or other state / federal trauma funding is sustaining, enhancing and improving the trauma system.	E
5. Administration attends 50% of the Trauma Committee meetings annually.	
6. Responsible for the administrative commitment to the trauma program as evidenced by a signed Board Resolution, signed and updated every 3 years, that reflects the components of the trauma center : a. trauma medical director's authority to manage the trauma program b. trauma program manager's authority and ability to oversee trauma care from admission to discharge c. trauma performance improvement process d. trauma registry e. trauma outreach education f. injury prevention g. RAC participation by the Trauma Program Manager	E
7. The defined administrator will complete the following courses for emergency management: a. Incident Command System Training – ICS 100 b. Incident Command System Training – ICS 200	E
8. Documented evidence of participation in scheduled emergency response exercises.	D
9. Evidence of a minimum of 50% attendance at emergency response (disaster) committee for the hospital.	D
