Request for Proposal (RFP) for Initial or Renewal
North Carolina Trauma Center Designation

The North Carolina Office of Emergency Medical Services
Division of Health Service Regulation
Department of Health and Human Services

Legal Name of Hospital Seeking Designation:

Type of Review: Initial ☐ Renewal ☐

Level of Review: Level I ☐ Level II ☐ Level III ☐

Name of Person completing RFP:

Date of Submission:

If this is a renewal, date current designation ends:

Click here to enter a date.
Background Information

1. Provide a description of the history of your trauma service, (i.e., initial designation, growth of service, etc). Be sure to address how the trauma medical director oversees all aspects of the multidisciplinary care from the time of injury through discharge.

   

2. Describe any administrative changes at your facility that have impacted the trauma program since the last review.
   
   ☐ N/A

   

3. Describe your hospital with respect to governance, as well as affiliations (with other hospitals, etc.).

   

4. Are all trauma activities within one facility?
   
   ☐ Yes  ☐ No*

   * If “No,” describe multi-facility relationships.

   

5. Briefly list any deficiencies from last review and how they were corrected (list with bulleted points/numbered points):
   
   ☐ N/A

   

6. Briefly list any weaknesses from last review and how they have been addressed (list with bulleted points/numbered points):

   

Reporting year for this review (12 months and should not be older than 14 months):

Click here to enter a date. - Click here to enter a date.
HOSPITAL INFORMATION

A. General Information

Tax Status:

1. Profit ☐
2. Non-profit ☐
3. Government ☐

Is there a Medical School Affiliation?

☐ Yes* ☐ No

*If yes, Name:

B. What is the hospital Payer Mix (use whole numbers, do not include percent sign):

<table>
<thead>
<tr>
<th>Payer</th>
<th>All Patients (%)</th>
<th>Trauma Patients (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commercial</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicare</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicaid</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HMO/PPO</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uncompensated/Indigent</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Define Other:
- C. Hospital Beds (do not include neonatal beds):

<table>
<thead>
<tr>
<th>Hospital Beds</th>
<th>Adult</th>
<th>Pediatric</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Licensed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staffed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average Census</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

C. Does the trauma center leadership actively participate in the regional and state system? (CD 1-2, CD 1-3) Type II/L 1-3

☐ Yes ☐ No If yes, please describe participation:

II. DESCRIPTION / TRAUMA LEVEL AND ROLES

1. Does this trauma center have an integrated, concurrent performance improvement and patient (PIPS) program to ensure optimal care and continuous improvement in care? (CD 2-1) Type I / L1-3

☐ Yes ☐ No

2. Does the trauma center demonstrate surgical commitment? (CD 2-2) Type I / L1-3

☐ Yes ☐ No
• If 'No', please describe:

3. Does the trauma center provide the necessary human and physical resources (physical plant and equipment) to properly administer acute care consistent with their level of verification? (CD 2-3) Type II / L1-3

☐ Yes  ☐ No

4. Level I or II applicants, does the trauma center admit at least 1,200 trauma patients yearly or have 240 admissions with an Injury Severity Score of more than 15? (CD 2-4) Type I / L1-2

☐ Yes  ☐ No

5. Complete the table below for total number of emergency department (ED) visits for reporting year with ICD-10 code between S00-S99, T07, T14, T20-T28, T30-T32, T71, T79.A1-T79.A

<table>
<thead>
<tr>
<th>ED Visits</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Admitted Injured Patients (Regardless of Service)</td>
<td></td>
</tr>
<tr>
<td>Blunt Trauma Percentage</td>
<td></td>
</tr>
<tr>
<td>Penetrating Trauma Percentage</td>
<td></td>
</tr>
<tr>
<td>Thermal Percentage</td>
<td></td>
</tr>
<tr>
<td>Total number of ED visits</td>
<td></td>
</tr>
</tbody>
</table>

6. Disposition ED Trauma Visits

<table>
<thead>
<tr>
<th>Admitted</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>DOA</td>
<td></td>
</tr>
<tr>
<td>ED Deaths Excluding DOAs</td>
<td></td>
</tr>
<tr>
<td>Transferred Out</td>
<td></td>
</tr>
<tr>
<td>Discharged</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
</tr>
</tbody>
</table>

7. Total Trauma Admissions by Service:

<table>
<thead>
<tr>
<th>Service</th>
<th>Number of Admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trauma</td>
<td></td>
</tr>
<tr>
<td>Orthopaedic</td>
<td></td>
</tr>
<tr>
<td>Neurosurgery</td>
<td></td>
</tr>
<tr>
<td>Other Surgical</td>
<td></td>
</tr>
<tr>
<td>Burn</td>
<td></td>
</tr>
<tr>
<td>Non-Surgical</td>
<td></td>
</tr>
<tr>
<td>Total Trauma Admissions</td>
<td></td>
</tr>
</tbody>
</table>

8. Based on the number of Non-surgical admits (NSA) from Table 7, please complete the following:

<table>
<thead>
<tr>
<th>Non-surgical admissions (NSA)</th>
<th>ISS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0-9</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of patients admitted to a non-surgical service (from Chapter 2, Table 7)</td>
<td></td>
</tr>
</tbody>
</table>
9. Total number of direct admissions: ________________

10. Does the trauma program admit more than 10% of injured patients to non-surgical services? (CD 5-18) Type II / L1-3

☐ Yes  ☐ No

   a. Were all patients in table 8 reviewed by the TPM and TMD for appropriateness of admission and other opportunities for improvement?  ☐ Yes  ☐ No
   b. Have documentation available at the time of the site visit as attachment 2-1.

11. Injury Severity and Mortality.

<table>
<thead>
<tr>
<th>ISS</th>
<th>(A)Total Number of Admissions</th>
<th>(B)Total Number of Death from Admissions by ISS</th>
<th>Percent Mortality (B over A)</th>
<th>Number Admitted to Trauma Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-9</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10-15</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16-24</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt;or=25</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The total admissions for tables 7 and 11 should be the same. If there is an inconsistency in the totals, please explain: ______________________________________________________________

12. Does the trauma director have responsibility and authority for determining each general surgeon’s ability to participate on the trauma panel based on an annual review through the trauma PIPS program and hospital policy? (CD 2-5) Type II / L1-3

☐ Yes  ☐ No

13. Do trauma surgeons take in-house call? (CD 2-6) Type I / L1-3

☐ Yes  ☐ No

- Qualified attending surgeons must participate in major therapeutic decisions, be present in the emergency department for major resuscitations, be present at operative procedures, and be actively involved in the critical care of all seriously injured patients.

- A resident in postgraduate year 4 or 5 or an attending emergency physician who is part of the trauma team may be approved to begin resuscitation while awaiting the arrival of the attending surgeon but cannot independently fulfill the responsibilities of, or substitute for, the attending surgeon.

Describe trauma surgeon coverage:

_____________________________________________________________________

14. What percent of the time is the attending trauma surgeon present in the ED on patient arrival or within 15 minutes (30 minutes for Level III Trauma Centers) of arrival for the highest level of activation? (CD 2–7, CD
5-14, CD 5-1150 Type II / L1-3: __________

- Have data available at the time of the site visit as attachment 2-2.

15. Is the attendance threshold of 80% met for the attending trauma surgeon presence in the emergency department (refer to table 2 in chapter 5)? (This includes responding for trauma patients who are subsequently transferred to another facility). (CD 2–8) Type I / L1-3

☐ Yes ☐ No

16. Is the trauma attending surgeon’s arrival (within 15 minutes (L1-2) / within 30 minutes (L3) for patients appropriately monitored by the hospital’s trauma PIPS program? (CD 2–9) Type I / L1-3

☐ Yes ☐ No

17. Is the trauma surgeon dedicated to the trauma center while on call? (CD 2–10) Type II / L1-3

☐ Yes ☐ No

18. Is there a published backup call schedule for the trauma surgeons? (CD 2–11). Type II / L1-3

☐ Yes ☐ No

19. Does the facility participate in regional disaster management plans and exercises? (CD 2–22) Type II / L1-3

☐ Yes ☐ No

III. PREHOSPITAL TRAUMA CARE

1. Briefly describe the air medical support services available for your trauma program, including roto-wing and fixed wing services:


2. Does your hospital provide on-line medical control for prehospital trauma patients?

☐ Yes ☐ No

- If ‘Yes’, please briefly describe:


3. How does the trauma program participate in the training of prehospital personnel, the development and improvement of prehospital care protocols, and performance improvement and patient safety programs? (CD 3–1) Type II / L1-3


4. Describe how protocols that guide prehospital trauma care established by the trauma health care team, including surgeons, emergency physicians, medical directors for EMS agencies, and basic and advanced prehospital personnel: (CD 3–2) Type II / L1-3

5. Is the trauma director involved in the development of the trauma center’s bypass (divert) protocol? (CD 3–4) Type II / L1-3
   ☐ Yes ☐ No

6. Is the trauma surgeon involved in the bypass (divert) decision? (CD 3–5) Type II / L1-3
   ☐ Yes ☐ No

7. Was the trauma center on bypass (divert) more than 5 percent of the time during the reporting year? (CD 3–6) Type II / L1-3
   ☐ Yes ☐ No
   • Please complete Bypass (Divert) Appendix #3.

8. If the trauma center was required to go on bypass or to divert, what is the process? (CD 3–7) Type II / L1-3

IV. INTERHOSPITAL TRANSFER

1. Does your facility have a set of criteria that identifies patients who should be considered for transfer? (CD 4–2) Type II / L1-3
   ☐ Yes ☐ No
   • If ‘Yes’, please describe:

2. Is there direct physician-to-physician contact when patients are transferred out of your facility? (CD 4–1) Type II / L1-3
   ☐ Yes ☐ No
   • If ‘Yes’, how is this contact initiated and documented?
Is there direct physician-to-physician contact when patients are transferred into your facility?

☐ Yes  ☐ No
  • If ‘Yes’, how is this contact initiated and documented?

3. Does your trauma service routinely evaluate all transfers through the PIPS program? (CD 4–3, CD 16-8) Type II / L1-3

☐ Yes  ☐ No
  • If ‘Yes’, please describe the process:

4. What is the total number of transfers out? Please complete the table below. The total of transfers in column 2 + column 3 in the table should = the total number of transfers out.

Total transfers out: ____________

<table>
<thead>
<tr>
<th>1. Transfer Category</th>
<th>2. Number of transfers out &lt; 24 hrs</th>
<th>3. Number of transfers out &gt; 24 hrs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pediatrics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hand</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orthopaedics*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pelvic ring/acetabular fxs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Soft tissue coverage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other orthopaedics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neurosurgery*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Replantation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vascular/aortic injuries</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiac (Bypass)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facial trauma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Plan Repatriation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Orthopaedics and neurosurgery categories should exclude hand and spine injuries.*

5. What is your benchmark for the length of time between patient arrival, decision to transfer, and patient departure? ___________________
6. Is this parameter tracked as a part of the PIPS process?
☐ Yes  ☐ No

V. HOSPITAL ORGANIZATION AND THE TRAUMA PROGRAM

A. Hospital Commitment

1. Does the hospital have the commitment of the institutional governing body and medical staff to become or maintain a trauma center designation? (CD 5–1) Type I / L1-3
☐ Yes  ☐ No
   • Please have resolutions available at the time of the site visit as attachment 5-1.

2. Is the administrative support reaffirmed continually (every 4 years) and current at the time of verification? (CD 5–2) Type II / L1-3
☐ Yes  ☐ No
   • Briefly describe the administrative commitment to the trauma program (list items by numbers or bullet points):

3. Please list specific budgetary support for the trauma program such as personnel, education and equipment:

4. Is the medical staff support reaffirmed continually (every 4 years) and current at the time of verification? (CD 5–3) Type II / L1-3
☐ Yes  ☐ No
   • Briefly describe the medical staff commitment to the trauma program (list items by numbers or bullet points):

5. Does the trauma program involve multiple disciplines and transcend normal departmental hierarchies? (CD 5–4) Type II / L1-3
☐ Yes  ☐ No
   • Have an organizational chart available at the time of the site visit as attachment 5-2.
B. Trauma Program Manager (TPM)

6. Trauma program manager (name): ________________________________
   - Have the TPM job description available at the time of the site visit as attachment 5-3.

7. Education:
   a. Associate in Nursing ☐
   b. Bachelor in Nursing ☐
   c. Masters in Nursing ☐
   d. Other Degree ☐
   If ‘Other’ degree, please describe: ________________________________

8. TPM reporting status. (Check all that apply)
   a. TMD ☐
   b. Administration ☐
   c. Other (if other, please define): ________________________________

9. How many years has the TPM been at that position or date of appointment to this position?
   __________________

10. Total number of FTE's: __________________
    - List the number of support personnel including names, titles, and FTEs:
      __________________

11. Does the TPM show evidence of educational preparation (a minimum of 16 hours of internal or external trauma-related continuing education per year - CD 5-24 / Type II / L1-2) and clinical experience in the care of injured patients? (CD 5-22) Type II / L1-3
    ☐ Yes ☐ No

12. Is the TPM full-time and dedicated to the trauma program? (CD 5-23) Type II / L1-2
    ☐ Yes ☐ No

C. Trauma Medical Director (TMD)

Name: ________________________________

13. Is the TMD a current board-certified/eligible for certification surgeon or an ACS Fellow with a special interest in trauma care? (CD 5-5) Type I / L1-3 (Yes/No)
    a. Does the TMD participate in trauma call? (CD 5-5) Type I / L1-3
       ☐ Yes ☐ No
    b. Briefly describe the TMD's reporting structure:
       ________________________________
c. Provide information about the TMD on Appendix #1.
d. Have the job description for the TMD available at the time of the site visit as attachment 5-4.

14. Does the TMD have documented 16 hours annually or 64 hours in the past 4 years of external trauma-related CME? (CD 5-7) Type II / L1-2

☐ Yes  ☐ No  ☐ N/A Level III

15. Is the TMD a member and an active participant in national or regional trauma organizations? (CD 5-8) Type II / L1-2

☐ Yes  ☐ No  ☐ N/A Level III

• If yes, please list:

16. Does the TMD have the authority to manage all aspects of trauma care? (CD 5–9) Type II / L1-3

☐ Yes  ☐ No

17. Does the TMD chair (CD 5-25) attend a minimum of 50% of the multidisciplinary trauma peer review committee meetings? (CD 5-10, CD 16-15) Type II / L1-3

☐ Yes  ☐ No

18. Does the TMD, in collaboration with the TPM have the authority to correct deficiencies in trauma care or exclude from trauma call the trauma team members who do not meet specified criteria? (CD 5-11) Type II / L1-3

☐ Yes  ☐ No

19. Does the TMD perform an annual assessment of the trauma panel providers in the form of Ongoing Professional Practice Evaluation (OPPE) and Focused Professional Practice Evaluation (FPPE) when indicated by findings of the PIPS process? (CD 5-11) Type II / L1-3

☐ Yes  ☐ No

a. Describe the assessment process at your center:

b. Have documentation available at the time of the site visit as attachment 5-5.

20. Does the TMD have the responsibility and authority to ensure compliance with the verification requirements? (CD 5-9, CD 5-11) Type II / L1-3

☐ Yes  ☐ No

21. Does the TMD direct more than one trauma center? (CD 5-12) Type II / L1-3

☐ Yes  ☐ No
D. Trauma Activations

22. Are the require criteria for the highest level of activation included? (CD 5–13) Type II / L1-3

☐ Yes  ☐ No

- List your highest level of activations:


23. Who has the authority to activate the trauma team? (check all that apply)

a. EMS  ☐
b. ED Physician  ☐
c. ED Nurse  ☐
d. Trauma Surgeon  ☐

24. Does the facility have a multilevel response?

☐ Yes  ☐ No

25. Do you have geriatric-trauma activation criteria?

☐ Yes  ☐ No

- If ‘Yes’, please describe:


26. Number of levels of activation (include consults) Statistics for level of response (CD 5-14, 5-15, 5-16)

<table>
<thead>
<tr>
<th>Level</th>
<th>Number of activations</th>
<th>Percent of total activations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Highest</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intermediate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lowest (Consult)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>100%</td>
</tr>
</tbody>
</table>

27. Which trauma team members respond to each level of activation? (CD 5-13, CD 5-14)

<table>
<thead>
<tr>
<th>Activation Level</th>
<th>Responder</th>
<th>Highest</th>
<th>Intermediate</th>
<th>Lowest</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

28. Do you evaluate your activation criteria as part of the PIPS process? (CD 5-16) Type II / L1-3

☐ Yes  ☐ No
29. Does the center have a clearly defined response expectation for the trauma surgical evaluation of the limited-tier patients requiring admission? (CD 5-16) Type II / L1-3

☐ Yes  ☐ No

30. Are seriously injured patients admitted to or evaluated by an identifiable surgical service staffed by credentialed providers? (CD 5-17) Type II / L1-2

☐ Yes  ☐ No  ☐ N/A Level III

31. Does the structure of the trauma program allow the trauma medical director to have oversight authority for the care of the injured patients who may be admitted to individual surgeons? (CD 5-17) Type II / L3

☐ Yes  ☐ No  ☐ N/A Level I or II

• If ‘No’, please explain:

32. Is there sufficient infrastructure and support to the trauma service to ensure adequate provision of care? (CD 5-19) Type I / L1-2

☐ Yes  ☐ No  ☐ N/A Level III

VI. GENERAL SURGERY

1. Describe the organization of your trauma service. (Also, include number of residents, midlevel providers, etc., that participate on the trauma service)

2. Are all of the general surgeons (trauma surgeons on call panel) U.S. or Canadian board-certified/eligible for certification according to the current requirements? (CD 6–2) Type II / L1-3

☐ Yes  ☐ No

If no, please explain:

• List all surgeons currently taking trauma call on Appendix #2.

3. Do all of the trauma panel surgeons have privileges in general surgery? (CD 6–4) Type II / L1-3

☐ Yes  ☐ No
4. Define the credentialing criteria/qualifications for serving on the trauma panel in addition to hospital credentials (list by bullet points or numbers):

5. Briefly describe how the TMD oversees all aspects of the multidisciplinary care, from the time of injury through discharge:

6. Is there 50% greater attendance documented by each of the general surgeons at the multidisciplinary trauma peer review committee? (CD 6-8, CD 16-15) Type II / L1-3

☐ Yes  ☐ No

- List each general surgeon and his/her annual percentage of trauma peer review committee meeting attendance in Appendix #2.

7. Do all the trauma surgeons who take trauma call have documented 16 hours annually or 64 hours in the past 4 years of external trauma-related CME, or have they all participated in an internal education process conducted by the trauma program based on the principles of practice-based learning and the PIPS program? (CD 6-10) Type II / L1-2

☐ Yes  ☐ No  ☐ N/A Level III

- If internal process is used, please describe the process:

VII. EMERGENCY MEDICINE

1. Have a copy of the ED trauma flow sheet available at the time of the site visit as attachment 7-1.

2. Briefly describe the initial credentialing requirements for nurses who treat trauma patients in the ED:
   a. Nursing staff demographics (use whole numbers, do not include percent sign)
      i. Average years of experience: __________
      ii. Annual turnover %: __________
      iii. Percentage of nurses that are travelers: __________
   b. Nursing Education (use whole numbers, do not include percent sign)
      i. % ATCN: __________
      ii. % ENPC: __________
      iii. % TNCC: __________
      iv. % PALS: __________
      v. % ACLS: __________
      vi. % TCAR: __________
      vii. % Other (enter description and percentage): ________________
c. Extra certifications for ED nursing staff (use whole numbers, do not include percent sign)
   i. % CCRN: ____________
   ii. % CEN: ____________
   iii. % PCEN: ___________
   iv. % CNOR: ____________
   v. % CPAN: ____________
   vi. % Other (enter description and percentage): ___________________________

3. Briefly describe continuing trauma-related education for the nurses working in ED:

4. Does the emergency department have a designated emergency physician director supported by an appropriate number of additional physicians to ensure immediate care for injured patients? (CD 7–1) Type I / L1-3
   ☐ Yes ☐ No

5. Please describe hours of physician coverage and physician staffing patterns:

6. Are emergency department physicians present in the emergency department at all times? (CD 7-2) Type I / L1-2
   ☐ Yes ☐ No ☐ N/A Level III

7. Do emergency physicians ever respond to in-house emergencies?
   ☐ Yes ☐ No
   • If yes, briefly describe how the ED covered in their absence:

8. Is there an emergency medicine residency training program?
   ☐ Yes ☐ No
   • If ‘Yes’, is there supervision provided by an in-house attending emergency physician 24 hours per day? (CD 7-4) Type II / L1-3
     ☐ Yes ☐ No

9. Are the roles of emergency physicians and trauma surgeons defined, agreed on, and approved by the director of trauma services? (CD 7–5) Type II / L1-3
10. Are all of the emergency physicians who care for injured patients U.S. or Canadian board-certified/eligible for certification according to the current requirements? (CD 7–6) Type II / L1-3

☐ Yes  ☐ No

If no, please explain:

- List all emergency department physicians taking trauma call on Appendix #9.

11. Are the emergency physicians on the call panel regularly involved in the care of injured patients? (CD 7–7) Type II / L1-3

☐ Yes  ☐ No

12. Is there a representative from the emergency department participating in the prehospital PIPS program? (CD 7–8) Type II / L1-3

☐ Yes  ☐ No

13. Is there a designated emergency physician liaison available to the trauma director for PIPS issues that occur in the emergency department? (CD 7–9) Type II / L1-3

☐ Yes  ☐ No

14. Provide information about the emergency medical liaison to trauma program on Appendix #8.

15. Describe how the emergency physicians are actively involved with the overall trauma PIPS program: (CD 7–10) Type II / L1-3

16. Does the emergency medicine liaison on the multidisciplinary trauma peer review committee attend a minimum of 50% of the committee meetings? (CD 7–11, CD 16-15) Type II / L1-3

☐ Yes  ☐ No

17. Does the liaison from emergency medicine accrue an average of 16 hours annually or 64 hours in 4 years of verifiable external trauma-related CME? (CD 7-12) Type II / L1-2

☐ Yes  ☐ No

18. Do all the emergency physicians (non-liaison) have documented 16 hours annually or 64 hours in the past 4 years of external trauma-related CME, or have they all participated in an internal education process conducted by the trauma program based on the principles of practice-based learning and the PIPS program? (CD 7-13) Type II / L1-2
☐ Yes  ☐ No  ☐ N/A Level III

- If internal process is used, please describe the process:

☐ ☐ ☐

19. Have all of the physicians who are board certified/eligible in emergency medicine successfully completed the ATLS course at least once? (CD 7–14) Type II / L1-3

☐ Yes  ☐ No

20. Do the other physicians who are board certified/eligible other than emergency medicine have current ATLS status? (CD 7–15) Type II / L1-3

☐ Yes  ☐ No

VIII. NEUROSURGERY

1. Is there a designated neurologic surgeon liaison? (CD 8-1) Type 1 / L1-2

☐ Yes  ☐ No  ☐ N/A Level III

- Provide information about the neurosurgeon liaison to the trauma program on Appendix #4.

2. Are qualified neurosurgeons regularly involved in the care of all TBI and spinal cord injured patients? (CD 8-2, CD 8-11) Type I / L1-2

☐ Yes  ☐ No  ☐ N/A Level III

3. Are qualified neurosurgeons credentialed by the hospital with general neurosurgical privileges? (CD 8-11) Type I / L1-2

☐ Yes  ☐ No  ☐ N/A Level III

4. What is the number of emergent craniotomies in TBI patients done within 24 hours of admission during the reporting period?

5. What percentage of patients with TBI does this present (denominator all TBI or severe TBI)?

6. What is the percentage of severe TBI patients having ICP monitors inserted within 48 hours of admission during the reporting period?

   For those severe TBI patients who do not undergo ICP monitoring, is there a PI process in place to review for appropriateness?

☐ Yes  ☐ No

7. List the institutional criteria (diagnosis) that require a 30 minute response by the neurosurgeon:
8. Is there a published backup call schedule for the neurosurgeons with formerly arranged contingency plans in case the capability of the neurosurgeon, hospital, or system to care for neurotrauma patients is overwhelmed? (CD 8-3) Type I / L1-2
☐ Yes ☐ No ☐ N/A Level III

9. Does the facility have an ACGME-certified neurosurgery residency program?
☐ Yes ☐ No
  a. If ‘Yes’, how many neurosurgery residents are there in the ACGME-certified training program?
  ______________________________________
  b. Does the facility have any other neurosurgery training programs (e.g., osteopathic residency, fellowship programs)? ☐ Yes ☐ No
  c. If so, please list: __________________________________________________________

10. Does the center have a predefined and thoroughly developed neurotrauma diversion plan that is implemented when the neurosurgeon on call becomes encumbered? (CD 8-4) Type II / L1-2
☐ Yes ☐ No ☐ N/A Level III

11. Does the hospital provide a formal published contingency plan for times in which a neurosurgeon is encumbered upon the arrival of a neurotrauma case? (CD 8–5) Type II / L1-3
☐ Yes ☐ No
  i. Please list the mechanisms used for contingency planning, e.g., published back-up schedule, resident coverage, etc. __________________________________________________________
  ii. Are all of the following included in the neurotrauma contingency plan?
    a. A credentialing process to allow the trauma surgeon to provide initial evaluation and stabilization of the neurotrauma patient: ☐ Yes ☐ No
    b. Transfer agreements with a similar or higher-level verified trauma center: ☐ Yes ☐ No
    c. Direct contact with the accepting facility to arrange for expeditious transfer or ongoing monitoring support: ☐ Yes ☐ No
    d. Monitoring of the efficacy of the process by the PIPS program: ☐ Yes ☐ No

12. Are the neurosurgeons dedicated to this hospital when on trauma call (ie - Not taking simultaneous call at another hospital)? (CD 8-6) Type II / L1-3
☐ Yes ☐ No
  • If ‘No’, is there a published back-up call schedule and does the PIPS process demonstrate the appropriate and timely care is provided? ☐ Yes ☐ No

13. Are all of the neurosurgeons who take trauma call U.S. or Canadian board-certified/eligible for certification according to the current requirements? (CD 8–10) Type II / L1-3
☐ Yes ☐ No ☐ N/A Level III
If no, please describe:

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\begin{tabular}{|c|}
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\end{tabular}
\end{center}}
\]

a. What is the number of neurosurgeons on the call panel?

b. List all neurosurgeons taking trauma call on Appendix #5.

14. Describe how the neurosurgery service is actively involved with the overall trauma PIPS program: (CD 8-12) Type II / L1-2

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\end{tabular}
\end{center}}
\]

☐ N/A Level III

15. Does the neurosurgery liaison attend a minimum of 50% of the multidisciplinary trauma peer review committee meetings? (CD 8-13, CD 16-15) Type II / L1-2

☐ Yes ☐ No ☐ N/A Level III

16. Does the neurosurgeon liaison have documented 16 hours annually or 64 hours in 4 years of verifiable, external trauma-related CME? (CD 8-14) Type II / L1-2

☐ Yes ☐ No ☐ N/A Level III

17. Do all the neurosurgery panelists (non-liaison) who take trauma call have documented 16 hours annually or 64 hours in the past 4 years of external trauma-related CME, or have they all participated in an internal education process conducted by the trauma program and the neurosurgical liaison based on the principles of practice-based learning and the PIPS program? (CD 8-15) Type II / L1-2

☐ Yes ☐ No ☐ N/A Level III

• If internal process is used, please describe the process:

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\begin{tabular}{|c|}
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\text{\hspace{1cm}}
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\end{tabular}
\end{center}}
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IX. ORTHOPAEDIC SURGERY

1. Are there physical and occupational therapists available 7 days a week to trauma patients? (CD 9-1) Type II / L1-2

☐ Yes ☐ No ☐ N/A Level III

2. Is there an Orthopaedic trauma OR available daily? (CD 9–2) Type I / L1-3

☐ Yes ☐ No
• Please describe:

3. Is there a mechanism in place to ensure operating room availability for musculoskeletal trauma cases can be scheduled without undue delay and not at inappropriate hours that might conflict with more urgent surgery or other elective procedures? (CD 9-3) Type II / L1-2

☐ Yes  ☐ No  ☐ N/A Level III

• Please describe:

4. Is there an orthopaedic surgeon who is identified as the liaison to the trauma program? (CD 9–4) Type I / L1-3

☐ Yes  ☐ No

• Provide information about the Orthopaedic surgeon liaison to the trauma program on Appendix #6.

5. Is the orthopaedic care trauma center overseen by an individual who has completed a fellowship in orthopaedic traumatology approved by the Orthopaedic Trauma Association (OTA)? (CD 9-5) Type I / L1

☐ Yes  ☐ No  ☐ N/A Level II or III

a. List the name(s), date and place of OTA fellowship on Appendix #7:

b. Does the facility have an orthopaedic trauma fellowship? ☐ Yes  ☐ No

c. Does the facility have an orthopaedic surgery residency program? ☐ Yes  ☐ No

6. Are the on-call orthopaedic team members dedicated to the hospital (i.e. Do not take call simultaneously at another hospital)? (CD 9–6, CD 9-12) Type II / L1-3

☐ Yes  ☐ No

a. If 'No', is there an effective back-up call system? ☐ Yes  ☐ No

b. If 'Yes', please describe the back-up call system:

7. Is there an orthopaedic team member promptly available in the trauma resuscitation area within 30 minutes when consulted by the surgical trauma team leader for multiple injured patients? (CD 9-7) Type II / L1-2

☐ Yes  ☐ No  ☐ N/A Level III
8. Does the performance improvement process ensure that care is timely and appropriate? (CD 9-8)
   Type II / L1-2
   ☐ Yes ☐ No ☐ N/A Level III

9. If the on-call orthopaedic surgeon is unable to respond promptly, is there a backup consultant (PGY 4 or higher) on-call available? (CD 9-9) Type II / L1-2
   ☐ Yes ☐ No ☐ N/A Level III

10. Has the trauma program director approved the backup call system that was designed by the orthopaedic trauma liaison? (CD 9-10) Type II / L1-2
    ☐ Yes ☐ No ☐ N/A Level III

11. Does the trauma center provide all the necessary resources for modern musculoskeletal trauma care, including instruments, equipment, and personnel, along with readily available operating rooms for musculoskeletal trauma procedures? (CD 2–3) Type II / L1-2
    ☐ Yes ☐ No ☐ N/A Level III

12. Are there protocols in placed for the following orthopaedic emergencies (CD 9-14) Type II / L1-2:
    1) The type and severity of pelvic and acetabular fractures that will be treated at the institutions as well as those that will be transferred out for care: ☐ Yes ☐ No ☐ N/A Level III
    2) The timing and sequence for the treatment of long bone fractures in multiply injured patients: ☐ Yes ☐ No ☐ N/A Level III
    3) The average wash out time for open fractures: ☐ Yes ☐ No ☐ N/A Level III

   a. Are these protocols included as part of the PIPS process? ☐ Yes ☐ No ☐ N/A Level III
   b. If 'Yes', please describe:

13. Average time to wash out of open tibial fractures secondary to a blunt mechanism; report as average and range: ____________________________

14. Average time to first antibiotic administration for open tibial fractures secondary to a blunt mechanism: ____________________________

15. The number of operations performed at this institution during the reporting year for pelvic ring and acetabular fractures secondary to a trauma mechanism, excluding isolated hip fractures:
    a. Pelvic ring injuries: ____________________________
    b. All acetabular fracture patterns: ____________________________
    c. How many of these patients had neurological deficits? ____________________________

   Note: Do not include hip fractures or injuries that result from a trip/fall.

16. Percent of femoral shaft fractures (defined as intramedullary rod, external fixation or ORIF) stabilized within 24 hours of admission: ____________________________

17. Does the orthopaedic service participate actively with the overall trauma PIPS program and the multidisciplinary trauma peer review committee? (CD 9–15) Type II / L1-3
18. Does the orthopaedic trauma liaison attend a minimum of 50% of the multidisciplinary trauma peer review meetings? (CD 9–16, CD 16-15) Type II / L1-3

☐ Yes  ☐ No

19. Are all of the orthopaedic surgeons who take trauma call U.S. or Canadian board-certified/eligible for certification according to the current requirements? (CD 9–17) Type II / L1-3

☐ Yes  ☐ No

If no, please explain:

- Number of orthopaedic surgeons on the trauma call panel?
- List all orthopaedic surgeons taking trauma call on Appendix #7.

20. Has the orthopaedic surgical liaison documented at least an average of 16 hours annually or 48 hours in 3 years of verifiable external trauma related continuing medical education CME? (CD 9–18) Type II / L1-2

☐ Yes  ☐ No  ☐ N/A Level III

21. Do all the orthopaedic trauma team members (non-liaison) who take trauma call have documented 16 hours annually or 64 hours in the past 4 years of external trauma-related CME, or have they all participated in an internal education process conducted by the trauma program and the orthopaedic liaison based on the principles of practice-based learning and the PIPS program? (CD 9-19) Type II / L1-2

☐ Yes  ☐ No  ☐ N/A Level III

- If internal process is used, please describe the process:

X. PEDIATRIC TRAUMA SURGERY

A. Pediatric Trauma Admissions

1. Define your pediatric population (by age):

2. Did your trauma program admit 100 or more injured children younger than 15 years of age during your reporting year?
☐ Yes  ☐ No

i. If ‘Yes’, are the following present? (CD 2-24) Type II / L1-3:
   a. A pediatric emergency area  ☐ Yes  ☐ No
   b. A pediatric intensive care unit  ☐ Yes  ☐ No
   c. Appropriate resuscitation equipment  ☐ Yes  ☐ No
   d. A pediatric-specific trauma PIPS program (CD 10-6/Type I)  ☐ Yes  ☐ No

ii. If ‘Yes’, are the trauma surgeons credentialed for pediatric trauma care by the hospital’s credentialing body?
   ☐ Yes  ☐ No

iii. Please describe credentialing process:

☐

3. If ‘No’, does your trauma program review the care of injured children through the PIPS program? (CD 2–25) Type II / L1-3
   ☐ Yes  ☐ No

4. Below, specify the number of pediatric trauma admissions (not to include DOA and ED deaths) for the 12-month reporting period:

<table>
<thead>
<tr>
<th>Service</th>
<th>Number of Admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trauma</td>
<td></td>
</tr>
<tr>
<td>Orthopaedic</td>
<td></td>
</tr>
<tr>
<td>Neurosurgical</td>
<td></td>
</tr>
<tr>
<td>Other Surgical *</td>
<td></td>
</tr>
<tr>
<td>Non-Surgical Service **</td>
<td></td>
</tr>
<tr>
<td>Total Pediatric Trauma Admissions</td>
<td></td>
</tr>
</tbody>
</table>

5. Injury Severity and Mortality (for admissions only)

<table>
<thead>
<tr>
<th>ISS Category</th>
<th>Number</th>
<th>Deaths</th>
<th>% Mortality</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-9</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10-15</td>
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<tr>
<td>16-24</td>
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<tr>
<td>&gt;= 25</td>
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</tbody>
</table>

6. Based on the number of Non-surgical admits (NSA) from Table 4, please complete the following:

<table>
<thead>
<tr>
<th>Non-surgical admissions (NSA)</th>
<th>ISS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0-9</td>
</tr>
<tr>
<td>Number of patients admitted to non-surgical service (from table 4 above)</td>
<td></td>
</tr>
<tr>
<td>Percent of total NSA</td>
<td></td>
</tr>
<tr>
<td>Total NSA with trauma consults</td>
<td></td>
</tr>
</tbody>
</table>
B. Splenic Injuries
1. Pediatric patients admitted with splenic injuries during the reporting year.

<table>
<thead>
<tr>
<th>Grade of Spleen Injury</th>
<th># of Splenic Injuries</th>
<th># with (IR) Embolization</th>
<th># of Splenorrhaphy</th>
<th># of Splenectomy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grade I</td>
<td></td>
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</tr>
<tr>
<td>Grade II</td>
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<td>Grade III</td>
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<tr>
<td>Grade IV</td>
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<tr>
<td>Grade V</td>
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<tr>
<td>TOTALS</td>
<td></td>
<td></td>
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<td></td>
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</tbody>
</table>

XI. COLLABORATIVE CLINICAL SERVICES

A. Anesthesiology
1. Are anesthesiology services available within 30 minutes for emergency operations? (CD 11–1) Type I / L1-3
   □ Yes □ No

2. Are anesthesiology services promptly available within 30 minutes for airway problems? (CD 11–2) Type I / L1-3
   □ Yes □ No

3. Is there an anesthesiologist who serves as the designated liaison to the trauma program? (CD 11–3) Type I / L1-3
   □ Yes □ No
   • Name: __________
   • Provide information about the anesthesiologist liaison to the trauma program on Appendix #10.

4. Does the facility have anesthesia services available in-house 24 hours a day? (CD 11-4) Type I / L1-2
   □ Yes □ No □ N/A Level III
   • If yes, which of the following:
     a. MD Anesthesiologist: □
     b. CRNA or Certified Anesthesiologist’s Assistants (C-AA): □
     c. Resident: □

5. Who fulfills the in-hospital requirements for anesthesia services? ____________________________

6. Number of anesthesiologists on staff? ____________________

7. How many anesthesiologists are on backup call during off-hours? ____________________
   • Describe the anesthesiology on-call schedule:
8. When anesthesiology senior residents or CRNAs or Certified Anesthesiologist's Assistants (C-AA) are used to fulfill availability requirements, are the attending anesthesiologists on call available within 30 minutes at all times, and present for all operations? (CD 11-5) Type I / L1-2

☐ Yes  ☐ No

- Describe how this is monitored at your institution:

9. Is the availability of the anesthesia services and the absence of delays in airway control or operations documented by the hospital PIPS process? (CD 11-6) Type II / L1-3

☐ Yes  ☐ No

10. Have all of the anesthesiologists taking call successfully completed an anesthesiology residency? (CD 11-10) Type I / L1-2

☐ Yes  ☐ No

11. Is the anesthesiologist liaison who takes trauma call a current board-certified/eligible for certification according to current requirements in anesthesiology? (CD 11-11) Type I / L1-2

☐ Yes  ☐ No

12. Does the anesthesiology liaison participate in the trauma PIPS process and attend at least 50% of the multidisciplinary trauma peer review meetings? (CD 11-12, CD 11-13, CD 16-15) Type II / L1-3

☐ Yes  ☐ No

B. Operating Room

1. Is the operating room adequately staffed and available within 15 minutes? (CD 11-14) Type I / L1-2

☐ Yes  ☐ No

- Number of operating rooms:
- Number of times when OR not available within 15 minutes for an emergent trauma case:
- Briefly describe the location of the operating suite related to the ED and ICU:

2. If the first operating room is occupied, is there a mechanism for providing additional staff for a second operating and is it monitored through the PIPS process? (CD 11-15, CD 11–16) Type II / L1-2
☐ Yes  ☐ No

a. What is the number of teams on call and their expected response time: _______________________

b. Describe how the backup team is called if the primary team is busy and how is this documented in the PIPS process:


c. Number of times the back-up team was called in: ______________

d. Describe your mechanism for OR availability for urgent trauma cases:


e. Describe your mechanism for OR availability for non-urgent trauma cases during daylight hours:


3. Is there a mechanism for documenting trauma surgeon presence in the operating room for all trauma operations? (CD 6–7) Type II / L1-3

☐ Yes  ☐ No

• If 'Yes', please describe:


4. Does the operating room have all essential equipment? (CD 11–19) Type I / L1-3

☐ Yes  ☐ No

5. Does the trauma center have the necessary equipment to perform craniotomy? (CD 11–20) Type I / L1-3

☐ Yes  ☐ No

Only Level III trauma centers that do not offer neurosurgery services are not required to have craniotomy equipment.

6. Does the center have cardiothoracic surgery capabilities available 24 hours per day and have cardiopulmonary bypass equipment (CPB)? (CD 11–21) Type II / L1

☐ Yes  ☐ No  ☐ N/A Level II or III

a. If there is not a CPB immediately available, is there a contingency plan? (CD 11–22) Type II / L1-2
b. If there is a transfer policy, does the trauma center review the patients transferred in their performance improvement process?
☐ Yes  ☐ No

7. Does the trauma center have an operating microscope available 24 hours per day? (CD 11–23) Type II / L1
☐ Yes  ☐ No  ☐ N/A Level II or III

C. Post-Anesthesia Car Unit (PACU)

1. Number of beds: ________________

2. Is the PACU ever used as an overflow for the ICU?
☐ Yes  ☐ No

3. Does the PACU have qualified nurses available 24 hours per day as needed during the patient’s post-anesthesia recovery phase? (CD 11-24) Type I / L1-3
☐ Yes  ☐ No

4. If the PACU is covered by a call team from home, is there documentation by the PIPS program that PACU nurses are available and delays are not occurring? (CD 11–25) Type II / L1-3
☐ Yes  ☐ No

        • If ‘Yes’, please describe:

5. Briefly describe credentialing requirements for nurses who care for trauma patients in PACU:

    a. Nursing Education (use whole numbers, do not include percent sign)
       i. % ENPC: ________________
       ii. % TNCC: ________________
       iii. % PALS: ________________
       iv. % ACLS: ________________
       v. % TCAR: ________________
       vi. % Other (enter description and percentage): ___________________________

    b. Extra certifications for ED nursing staff (use whole numbers, do not include percent sign)
       i. % CCRN: ________________
       ii. % CEN: ________________
       iii. % PCEN: ________________
       iv. % CNOR: ________________
       v. % CPAN: ________________
       vi. % Other (enter description and percentage): ___________________________

6. Does the PACU have the necessary equipment to monitor and resuscitate patients? (CD 11-26)
Type I / L1-3
☐ Yes  ☐ No

D. Radiology

1. Does the trauma center have policies designed to ensure that trauma patients who may require resuscitation and monitoring are accompanied by appropriately trained providers during transportation to
and while in the radiology department? (CD 11–28) Type II / L1-3

☐ Yes  ☐ No

- Please describe:

---

2. Who provides FAST for trauma patients? (Check all that apply)

a. Radiology  ☐
b. Surgery  ☐
c. ED Physician  ☐
d. None  ☐

---

3. Describe your institution's policy for obtaining FAST exams for injured patients:

---

4. Describe your institution's QI policy for FAST exams:

---

5. Is there adult and pediatric resuscitation and monitoring equipment available in the radiology suite?

☐ Yes  ☐ No

6. Are conventional radiography (CD 11-29 / L1-4) and computed tomography (CD 11-30 / L1-3) available 24 hours per day? Type I

☐ Yes  ☐ No

7. Is there an in-house radiology technologist and CT technologist 24 hours per day? (CD 11-31) Type I / L1-2

☐ Yes  ☐ No

8. Are radiologists available within 30 minutes in person or by teleradiology, when requested for the interpretation of radiographs? (CD 11-32) Type I / L1-3

☐ Yes  ☐ No

   a. Are radiologists in-house 24/7?  ☐ Yes  ☐ No
   b. If 'No', who reads x-rays after hours?
   c. How is diagnostic information from radiologic studies communicated to the trauma team?
   d. If an error is identified on initial radiologic interpretation, what is the policy for notifying the physician?

9. Are radiologists available within 30 minutes to perform complex imaging studies, or interventional procedures? (CD 11-33) L1-2
10. Is diagnostic information communicated in a written electronic form and in a timely manner? (CD 11-34) Type II / L1-3
   □ Yes  □ No

11. Is critical information deemed to immediately affect patient care verbally communicated to the trauma team in a timely manner? (CD 11–35) Type II / L1-3
   □ Yes  □ No

12. Do final reports accurately reflect the chronology and content of communications, including changes between preliminary and final interpretations? (CD 11–36) Type II / L1-3
   □ Yes  □ No

13. Are changes in interpretation between preliminary and final reports, as well as missed injuries monitored through the PIPS program? (CD 11–37) Type II / L1-3
   □ Yes  □ No
   a. Describe your institution’s process for tracking changes in radiology interpretation and missed injuries.
   b. Describe how these are monitored through PIPS:

14. Is there a radiologist who is appointed as liaison to the trauma program? (CD 11-38) Type II / L1-2
   □ Yes  □ No  □ N/A Level III
   • Name:________________________
   • Provide information about the radiologist liaison to the trauma program on Appendix #12.

15. Does the radiologist liaison to the trauma program attend at least 50% of the multidisciplinary trauma peer review meetings and educate the entire trauma team in the appropriate use of radiologic services? (CD 11–39, CD 11-40, CD 16-15) Type II / L1-2
   □ Yes  □ No  □ N/A Level III

16. Does the Radiology department participate in the trauma PIPS program by at least being involved in protocol development and trend analysis that relate to diagnostic imaging? (CD 11-41) Type II / L1-2
   □ Yes  □ No
   • Please describe:
17. Does the facility have a mechanism in place to view radiographic imaging from referring hospitals within their catchment area? (CD 11–42) Type II / L1-2

☐ Yes  ☐ No  ☐ N/A Lever III

- Describe your institution’s mechanisms to view these images:

18. Is the radiology liaison who takes trauma call a current board-certified/eligible for certification according to current requirements in radiology? (CD 11-43) Type II / L1-2

☐ Yes  ☐ No  ☐ N/A Lever III

19. Are interventional radiologic procedures and sonography available 24 hours per day? (CD 11-44) Type I / L1-2

☐ Yes  ☐ No  ☐ N/A Lever III

- Describe the institutional guidelines for interventional radiology response times and how they are tracked:

20. Is MRI capability available 24 hours per day? (CD 11-45) Type II / L1-2

☐ Yes  ☐ No  ☐ N/A Lever III

21. Is the MRI technologist arrival within 1 hour of being called documented and reviewed through the PIPS process? (CD 11–46) Type II / L1-2

☐ Yes  ☐ No  ☐ N/A Lever III

22. If Level III is the CT technologist in house 24 hours a day?

☐ Yes  ☐ No

  a. If no, does the PIPS program document and monitor the technologists’ time of arrival (to ensure arrival is within 1 hour of being called? (CD11-47)

     ☐ Yes  ☐ No

E. Intensive Care Unit (ICU)

1. ICU Beds.

   a. Total ICU beds (Includes medical, coronary, surgical, pediatric, etc): _____________
   b. Total Pediatric: _____________
   c. Total Surgical: _____________
   d. Do you have a step-down or intermediate care unit? ☐ Yes  ☐ No
   e. Describe how quality of care issues are resolved in the ICU:
2. Does your institution have palliative care available?
   □ Yes  □ No
   a. If 'Yes', describe how this palliative care team is incorporated into end of life issues:

   b. Total number of ICU deaths: _________
   c. Of these deaths, # of withdrawal of care: _________
   d. Of these deaths, # transferred to hospice care: _________

3. Is there a designated ICU for care of the critically injured trauma patient? (CD 11–48) Type I / L1
   □ Yes  □ No  □ N/A Level II or III

4. Is there a designated surgical ICU director who is currently board certified in surgical critical care? (CD 11-49) Type II / L1
   □ Yes  □ No  □ N/A Level II or III
   • Provide information about surgical critical care liaison to the trauma program on Appendix #13.

5. Is the SICU staffed by a dedicated physician team? (CD 11–50) Type II / L1
   □ Yes  □ No  □ N/A Level II or III

6. Are there appropriately trained physicians available in-house within 15 minutes 24 hours per day for the ICU? (CD 11–51, CD 11-55) Type I / L1-2
   □ Yes  □ No  □ N/A Level III
   a. Please describe how physician coverage of critically ill trauma patients is promptly available 24 hours per day:

   b. During the day:

   c. After hours:
d. Who responds to acute issues in the ICU after hours?

7. If the trauma attending provides coverage, is there a backup ICU attending identified and readily available? (CD 11-52) Type II / L1
   □ Yes  □ No  □ N/A Level II or III

8. Does the trauma center have a surgical director or co-director for the ICU who is responsible for setting policies and administration related to trauma ICU patients? (CD 11-53) Type II / L2-3
   □ Yes  □ No  □ N/A Level I

9. Is the ICU director or co-director a surgeon who is board certified/eligible for certification by the current standard requirements? (CD 11–54) Type II / L2-3
   □ Yes  □ No  □ N/A Level I

10. Does the trauma surgeon retain responsibility for the patient and coordinate all therapeutic decisions in the ICU? (CD 11-58) Type I / L1-3
    □ Yes  □ No

11. Is the trauma surgeon kept informed of and concurs with major therapeutic and management decisions made by the ICU team? (CD 11-59) Type I / L1-3
    □ Yes  □ No

12. Does the PIPS program document the timeliness and appropriate ICU care and coverage is being provided? (CD 11-60) Type II / L1-3
    □ Yes  □ No

13. Is there designated ICU liaison to the trauma service? (CD 11–61) Type II / L1-3
    □ Yes  □ No
    - Name: ______________________________

14. Does the ICU liaison attend at least 50% of the multidisciplinary trauma peer review committee meetings? (CD 11–62, CD 16-15) Type II / L1-3
    □ Yes  □ No

15. Has the ICU liaison documented at least an average of 16 hours annually or 64 hours in 4 years of verifiable external trauma related continuing medical education CME? (CD 11–63) Type II / L1-2
16. Do all the ICU panelists (non-liaison) who take trauma call have documented 16 hours annually or 64 hours in the past 4 years of external trauma-related CME or have they all participated in an internal education process conducted by the trauma program and the neurosurgical liaison based on the principles of practice-based learning and the PIPS program? (CD 11–64) Type II / L1-2

☐ Yes  ☐ No  ☐ N/A Level III

17. Are qualified critical care nurses available 24 hours per day to provide care during the ICU phase? (CD 11-65) Type I / L1-3

☐ Yes  ☐ No

18. Briefly describe the initial credentialing requirements for nurses who care for trauma patients in the ICU:

a. Nursing staff demographics (use whole numbers, do not include percent sign)
   i. Average years of experience: __________
   ii. Annual turnover %: __________
   iii. Percentage of nurses that are travelers: __________

b. Nursing Education (use whole numbers, do not include percent sign)
   i. % ATCN: __________
   ii. % ENPC: __________
   iii. % TNCC: __________
   iv. % PALS: __________
   v. % ACLS: __________
   vi. % TCAR: __________
   vii. % Other (enter description and percentage): __________

c. Extra certifications for ED nursing staff (use whole numbers, do not include percent sign)
   i. % CCRN: __________
   ii. % CEN: __________
   iii. % PCEN: __________
   iv. % CNOR: __________
   v. % CPAN: __________
   vi. % Other (enter description and percentage): __________

19. Briefly describe continuing trauma-related education for the nurses working in ICU:

20. The patient/nurse ratio does not exceed 2:1 for critically ill patients in the ICU. (CD 11-66) Type II / L1-3

☐ Yes  ☐ No

   • If 'No', please describe ____________________________________________________________________________

21. Does the ICU have the necessary equipment to monitor and resuscitate patients? (CD 11-67) Type I / L1-3

☐ Yes  ☐ No

22. Is intracranial pressure monitoring equipment available? (CD 11–68) Type I / L1-3

☐ Yes  ☐ No

F. Other Surgical Specialists
1. Are the following surgical specialists available? (CD 11-70, CD 11-71) Type I / L1-2

☐ Yes  ☐ No  ☐ N/A Level  III

Check all available surgical specialists:

a. Orthopaedic surgery
b. Neurosurgery
c. Cardiac surgery (not required for L2)
d. Thoracic surgery
e. Vascular surgery
f. Hand surgery
g. Microvascular surgery
h. Plastic surgery
i. Obstetric and Gynecologic surgery
j. Ophthalmology
k. Otolaryngology
l. Urology

2. For all patients being transferred for specialty care, such as burn care or replantation surgery, cardiopulmonary bypass capability, complex ophthalmologic surgery, or high-complexity pelvic fractures, agreements with a similar or higher-qualified verified trauma center should be in place.

i. For complex cases being transferred out, does the contingency plan (CD 8–5, Type II / L1-3) include the following:

a. A credentialing process to allow the trauma surgeon to provide initial evaluation and stabilization of the patient. ☐ Yes  ☐ No
b. Transfer agreements with similar or higher-verified trauma centers. ☐ Yes  ☐ No
c. Direct contact with the accepting facility to arrange for expeditious transfer or ongoing monitoring support. ☐ Yes  ☐ No
d. Monitoring of the efficacy of the process by the PIPS programs. ☐ Yes  ☐ No

ii. Which patients are being transferred for specialty care from your institution?

H. Medical Consultants

1. Does the medical specialists on staff include: (Check all that apply) (CD 11-73) Type II / L1-2

☐ N/A Level  III

a. Cardiology ☐ Yes  ☐ No
b. Internal medicine (required at L3 (CD 11-74) Type II) ☐ Yes  ☐ No
c. Gastroenterology ☐ Yes  ☐ No
d. Infectious disease ☐ Yes  ☐ No
e. Pulmonary medicine ☐ Yes  ☐ No
f. Nephrology ☐ Yes  ☐ No
g. Respective support teams (respiratory therapy/dialysis team/nutrition support) ☐ Yes  ☐ No
I. Support Services

1. Is a respiratory therapist available in the hospital call 24 hours per day? (CD 11–75) Type I / L1-2

☐ Yes  ☐ No  ☐ N/A Level III

2. Is acute hemodialysis available? (CD 11-77) Type II / L1-2

☐ Yes  ☐ No  ☐ N/A Level III

- Please describe what modes of dialysis are available:______________________________

3. Are nutritional support services available? (CD 11-79) Type II / L1-2

☐ Yes  ☐ No  ☐ N/A Level III

J. Clinical Laboratory and Blood Bank

1. Are laboratory services available 24 hours per day for the standard analysis of blood, urine, and other body fluids, including microsampling when appropriate? (CD 11-80) Type I / L1-3

☐ Yes  ☐ No

2. Is the blood bank capable of blood typing and cross matching? (CD 11-81) Type I / L1-3

☐ Yes  ☐ No

   a. What is the average turnaround time for type-specific blood (minutes)? __________
   b. What is the average turnaround time for full cross-matched blood (minutes)? __________

3. Does the blood bank have an adequate in-house supply of red blood cells, fresh frozen plasma, platelets, cryoprecipitate, and appropriate coagulation factors to meet the needs of injured patients? (CD 11–82) Type I / L1-2.

   Level III centers, the blood bank must have an adequate supply of packed red blood cells and fresh frozen plasma available within 30 minutes. (CD11-83) L3

☐ Yes  ☐ No

   a. How many units of packed red blood cells on average are available in the blood bank? __________
   b. How many units of plasma on average are available in the blood bank? __________
   c. How many units of platelets on average are available in the blood bank? __________
   d. Does the facility have uncross-matched blood immediately available? ☐ Yes  ☐ No
   e. Does you facility have thawed plasma immediately available? ☐ Yes  ☐ No
   f. For your highest level of activations, how is blood made available in the ED? __________________________________________________________________________

4. Does the facility have a massive transfusion protocol developed collaboratively between the trauma service and the blood bank? (CD 11-84) Type I / L1-3

☐ Yes  ☐ No

   a. Describe your MTP:

   __________________________________________________________________________

   b. Number of times activated in the last year: __________
   c. Describe your PIPS process, if any, for MTP activation:
5. Do you have an anticoagulation reversal protocol?

☐ Yes  ☐ No

a. Please describe:

b. Which products do you have available for rapid anticoagulation reversal other than Vitamin K and fresh frozen plasma?

c. Do they require approval for emergent use? ☐ Yes  ☐ No

6. Is there 24 hour per day availability for coagulation studies, blood gas analysis, and microbiology studies? (CD 11-85) Type I / L1-3

☐ Yes  ☐ No

K. Advanced Practitioners

1. Do the advanced practitioners who participate in the initial evaluation of trauma patients have current status in Advanced Trauma Life Support? (CD 11–86) Type II / L1-3

☐ Yes  ☐ No

• Have information about the advanced practitioners available at the time of the site visit as attachment 11-1.

2. Which advanced practitioners participate in the initial evaluation of trauma patients? (Check all that apply)

   a. Emergency medicine ☐
   b. Orthopaedics ☐
   c. Neurosurgery ☐
   d. Anesthesiology ☐
   e. Other (if other, please describe): ☐

3. Does the trauma program demonstrate appropriate orientation, credentialing processes, and skill maintenance for advanced practitioners, as witnessed by an annual review by the TMD? (CD 11–87) Type II / L1-3

☐ Yes  ☐ No

XII. REHABILITATION SERVICES

1. Who is the medical director of the rehabilitation program (name)? ____________________________

   a. Is this physician board certified? ☐ Yes  ☐ No
   b. If ‘Yes’, what specialty? ____________________________

2. Describe the composition of your in-house rehabilitation team:
3. Describe the role and relationship of the rehabilitation services to the trauma service (include where and when rehabilitation begins):


4. Is there a pediatric rehabilitation service? ☐ Yes ☐ No
   a. If 'Yes', please describe:

   

   b. If ‘No’, please describe how rehabilitation service are adapted for pediatric patients:

   

5. Which of the following services does the hospital provide? (Check all that apply)
   a. Physical therapy (CD 12-3) Type I / L1-3 ☐
   b. Social services (CD 12-4) Type II / L1-3 ☐
   c. Occupational therapy (CD 12-5) Type II / L1-2 ☐
   d. Speech therapy (Cd 12-6) Type II / L1-2 ☐

6. Are rehabilitation consultation services, occupational therapy, speech therapy, physical therapy, and social services available during the acute phase of care, including the ICU? (CD 12–2) Type II / L1-2
   ☐ Yes ☐ No ☐ N/A Level III

7. Is there a dedicated social worker for trauma service?
   ☐ Yes ☐ No
   • If 'No', what is the commitment from Social Services to the trauma patient?

   

8. Describe the support services available for crisis intervention and individual/family counseling:

   


9. Which of the following rehabilitation facility does the trauma center have? (CD 12–1) Type II / L1-2
   □ N/A Level  III
   a. Within the hospital’s physical facilities □
   b. Freestanding rehabilitation hospital □
      • If ‘inpatient rehabilitation unit’, is it CARF approved? □ Yes □ No
      • Number of inpatient beds: ____________
      • If ‘freestanding rehabilitation hospital’, does the hospital have transfer agreements? (CD 12-1) Type II / L1-2 □ Yes □ No

10. Is there a screening program in place for PTSD? □ Yes □ No

XIII. INTER-FACILITY TRANSFERS FOR HIGHER LEVEL OF CARE

1. Is there a direct contact of the physician or midlevel provider with a physician at the receiving hospital? (CD 4–1) Type II / L1-3
   □ Yes □ No

2. Briefly outline the protocol governing transfers and communication between this outside facility and your referral hospital:

   

3. With what agencies and facilities are transfer agreements in place?

   

4. Does this outside facility receive feedback from the referral center on the transfers?
   □ Yes □ No
      • If 'Yes', please list two examples of feedback that have occurred during the review period:

5. Is the trauma center able to read images from referring centers? (CD 11-41) Type II / L1-2
   □ Yes □ No

6. Does this rural facility use a mutually agreed upon imaging protocol (e.g. PACS) to ensure the referral trauma center has timely access to studies performed prior to transfer?
   □ Yes □ No

XIV. BURN PATIENTS

1. Number of burn patients admitted during the reporting year: ________________
2. Is there a separate burn team? ☐ Yes ☐ No

3. Number of burn patients transferred for acute care during reporting year.
   - Transferred In: __________
   - Transferred Out: __________

4. Does the trauma center that refer burn patients to a designated burn center have in place a written transfer agreement with the referral burn center? (CD 14–1) Type II / L1-3
   ☐ Yes ☐ No

XV. TRAUMA REGISTRY

1. Does the trauma registry support the PIPS process? (CD 15–3) Type II / L1-3
   ☐ Yes ☐ No
   • Describe how the registry is used in the PIPS process to identify and track opportunities for improvement:

2. Are at least 80% of the trauma cases entered into the trauma registry within 60 days of discharge? (CD 15-6) Type II / L1-3
   ☐ Yes ☐ No

3. Have all the registry staff attended or previously attended two courses within 12 months of being hired? (CD 15–7) Type II / L1-3
   ☐ Yes ☐ No
   If ‘Yes’, please check all that apply:
   • The American Trauma Society’s Trauma Registrar Course ☐
   • The Association of the Advancement of Automotive Medicine’s Injury Scaling Course ☐
   • Other (describe): ____________________________

4. Does the trauma program ensure that trauma registry confidentiality measures are in place? (CD 15-8) Type II / L1-3
   ☐ Yes ☐ No
   • If ‘Yes’, please explain:

5. Is there one full-time equivalent employee dedicated to the registry available to process the data set for each 500–750 admitted trauma patients annually? (CD 15–9) Type II / L1-3
   ☐ Yes ☐ No

6. Please describe the FTE staffing model for the registry:
7. Are there strategies for monitoring data validity for the trauma registry? (CD 15-10) Type II / L1-3

☐ Yes  ☐ No

• If ‘Yes’, please explain:

8. Describe the registry data validation process used by the center. For example provide the percentage of charts abstracted by another registrar, audits performed by benchmark sources, state audits, etc.:

XVI. PERFORMANCE IMPROVEMENT AND PATIENT SAFETY (PIPS)

A. Performance Improvement PI Program

1. Are the TMD and TPM knowledgeable and involved in trauma care collaboratively with guidance from the trauma peer review committee to identify events, develop corrective action plans, and ensure methods of monitoring, reevaluation, and benchmarking? (CD 2-17) Type II / L1-3

☐ Yes  ☐ No

2. Describe how your PI plan incorporates or assigns levels of review (primary, secondary, tertiary) for events/issues identified through the PI process:

3. Does the multidisciplinary trauma peer review committee meet regularly, with required attendance of medical staff active in trauma resuscitation, to review systemic and care provider issues, as well as propose improvements to the care of the injured? (CD 2–18) Type II / L1-3

☐ Yes  ☐ No

4. Is there a rigorous multidisciplinary performance improvement to evaluate overtriage and undertriage rates to attain the optimal goal of less than 5 percent undertriage? (CD 3–3) Type II / L1-3

☐ Yes  ☐ No

• Describe how your center defines over and undertriage and your PI process for undertriage: (CD 16–7) Type II / L1-3
5. Are nursing issues reviewed in the trauma PI Process? ☐ Yes  ☐ No
   - If 'No', briefly describe how nursing units ensure standards and protocols are followed:

6. Autopsies have been performed on what percentage of the facility's trauma deaths?________________
   - How are the autopsy findings reported to the trauma program?

7. Describe the PIPS plan that includes a comprehensive written plan outlining the configuration and identifying both adequate personnel to implement that plan and an operational data management system. (CD 16–1) Type II / L1-3

   a. Does the PIPS program have audit filters to review and improve pediatric and adult patient care? (CD 2–19) Type II / L1-3
      ☐ Yes  ☐ No

   b. List at least 3 adult specific PI filters:

   c. List at least 3 pediatric specific PI filters:

8. How is loop closure (resolution) achieved? (CD 16–2) Type II / L1-3

   a. Who is responsible for loop closure of both system and peer review issues?
b. List 2 examples of loop closure involving peer review issues during the reporting year:


c. List 2 examples of loop closure involving system issues during the reporting year:


9. How is PI integrated with the overall hospital PIPS program and the provision of feedback? (CD 16–3) Type II / L1-3


10. In an effort to reduce unnecessary variation in care provided, does the trauma program use clinical practice guidelines, protocols, and algorithms derived from evidenced-based validated resources? (CD 16–4) Type II / L1-3

☐ Yes ☐ No

11. Are all the process and outcome measures documented within the PIPS program plan and reviewed and updated annually? (CD 16–5) Type II / L1-3

☐ Yes ☐ No

B. Mortality Review

12. Are all trauma-related mortalities systematically reviewed with opportunities for improvement? (CD 16–6, CD 16-17, CD 16-18, CD 16-19) Type II / L1-3

☐ Yes ☐ No

Briefly describe the process:


 a. How many trauma deaths were there during the reporting year? 
 b. DOA: 
 c. Deaths in ED (DIED): 
 d. In-hospital (include OR): 

13. List the number of deaths categorized as follow:

 a. Mortality without Opportunity for Improvement: 
 b. Anticipated mortality with Opportunity for Improvement: 
 c. Unanticipated mortality with Opportunity for Improvement: 

C. Event Identification Review
14. Are there sufficient mechanisms available to identify events for review by the trauma PIPS program? (CD 16–10) Type II / L1-3

☐ Yes  ☐ No

- Describe how the events are verified and validated through the PIPS process. (CD 16–11) Type II / L1-3

15. Is there a Multidisciplinary Trauma Systems/Operations Committee? (CD 16–12). Type II / L1-3

☐ Yes  ☐ No

16. Is there documentation (minutes) reflecting the review of operational events and, when appropriate, the analysis and proposed corrective actions? (CD 16–13) Type II / L1-3

☐ Yes  ☐ No

17. Do identified problem trends undergo multidisciplinary trauma peer review? (CD 16–14) Type II / L1-3

☐ Yes  ☐ No

- If ‘Yes’, please describe:

18. Does the TMD ensure and document dissemination of information and findings from the multidisciplinary trauma peer review meetings to the non-liaisons physicians/surgeons on the trauma call panel? (CD 16–16, CD 16-17, CD 16-18, CD 16-19). Type II / L1-3

☐ Yes  ☐ No

- If ‘Yes’, please describe:

19. Provide a description of the two committees with trauma PI involvement, including Multidisciplinary Peer Review (Appendix #11a) and Multidisciplinary System Review in Appendix #11b.

D. Evidence Based Guideline

20. Does the facility have a manual for evidenced-based trauma guidelines and protocols?

☐ Yes  ☐ No

- If ‘Yes’, have a copy available at the time of the site visit as attachment 3-2.
- How many and how are they developed?
21. Has the trauma program instituted any 'evidenced-based' trauma guidelines and protocols since the last review?
☐ Yes  ☐ No

   a. If 'Yes', briefly describe:


   b. Briefly describe how compliance with the guidelines and protocols are monitored:


E. Geriatric Trauma

Geriatric Trauma Admissions, (age 65 or >) during the reporting year:
For the following include only patients 65 and older. Do not include isolated hip fractures from same level falls.

1. Table 1:

<table>
<thead>
<tr>
<th>ISS</th>
<th>(A)Total Number of Trauma Admissions</th>
<th>(B)Total Number of Trauma Deaths</th>
<th>Percent Mortality (B over A x 100)</th>
<th>Number Admitted to Trauma Service</th>
<th>Number Admitted to Other Surgical Services</th>
<th>Number Admitted to Non-Surgical Services</th>
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<td>0-9</td>
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</table>

2. Does the trauma program admit more than 10% of injured patients to non-surgical services? (CD 5-18)
Type II / L1-3

☐ Yes  ☐ No

   a. Were all patients in table 1 reviewed by the TPM and TMD for appropriateness of admission and other opportunities for improvement?
   ☐ Yes  ☐ No

   b. Have documentation available at the time of the site visit as attachment 16-1.

3. From the total number of geriatric trauma patients admitted (column (a) from table), the number of patients admitted after a fall from standing height, excluding patients with isolated hip fractures.

4. Does the hospital have an end of life policy for patients?  ☐ Yes  ☐ No

5. Do you have geriatric trauma guidelines or performance improvement projects?  ☐ Yes  ☐ No
6. Do you have a geriatric-trauma unit in your hospital? ☐ Yes ☐ No
   • If ‘Yes’, please describe:

7. Do your nurses caring for geriatric trauma patients receive any geriatric trauma training? ☐ Yes ☐ No
   • If ‘Yes’, please describe:

8. Are patients with isolated hip fractures included in your registry data? ☐ Yes ☐ No
   • If ‘Yes’, # of admissions:

9. Describe the hospital’s policy for admission of patients with isolate hip fracture:

XVII. EDUCATION ACTIVITIES / OUTREACH PROGRAMS

1. Is the trauma center engaged in public and professional education? (CD 17-1) Type II / L1-3
   ☐ Yes ☐ No

2. Does the trauma center provide some means of referral and access to trauma center resources? (CD 17-2)
   Type II / L1-2
   ☐ Yes ☐ No ☐ N/A Level III

3. Is this hospital a teaching facility?
   ☐ Yes ☐ No
a. If 'Yes', are the requirements of the Residency Review Committee met? (CD 5–20) Type II / L1-2

☐ Yes  ☐ No

b. Please describe the resident complement on the trauma service. L2


4. Does the trauma center provide a continuous rotation (12 consecutive months) in trauma surgery for senior residents (Clinical PGY 4-5; for peds includes PGY 3) that is part of an Accreditation Council for Graduate Medical Education - accredited program in any of the following disciplines: general surgery, orthopaedic surgery, or neurosurgery; or emergency medicine; or pediatric surgical fellowship (CD 10-28) or supports an acute care surgery fellowship consistent with the education requirements of the American Association for the Surgery of Trauma? (CD 17–3, CD 10-27) Type I/L1

☐ Yes  ☐ No  ☐ N/A Level II or III

• If 'Yes', list and briefly describe:


5. Does the facility have a trauma or surgical critical care fellowship?

☐ Yes  ☐ No

• If ‘Yes’, briefly describe:


6. Does the hospital provide a mechanism for trauma-related education for nurses involved in trauma care? (CD 17-4) Type II / L1-3

☐ Yes  ☐ No

7. Is there any hospital funding for physician, nursing or EMS trauma education?

☐ Yes  ☐ No

• If 'Yes', briefly describe:


8. Describe the trauma education program, including examples (list no more than 3 examples of each) for:
XVIII. PREVENTION

1. Does the trauma center demonstrate the presence of prevention activities that center on priorities based on local data? (CD 18–1) Type II / L1-3
   ☐ Yes ☐ No

2. What are the three leading causes of injury in your community?

3. Does the trauma center have someone in the leadership position that has injury prevention part of his or her job description? (CD 18–2) Type II / L1-3
   ☐ Yes ☐ No

4. Does the trauma center have an Injury Prevention Coordinator (separate from the TPM) with a demonstrated job description and salary support? (CD 18–2) Type II / L1
   ☐ Yes ☐ No ☐ N/A Level II or III
   a. Who is the designated injury prevention coordinator?
   b. Have the job description of the Prevention Coordinator available on site as attachment 18–1.

5. Is there a mechanism to identify patients who are problem drinkers? (CD 18–3) Type II / L1-3
   ☐ Yes ☐ No

6. Which screening instrument and cutoff scores are being used? (Check all that apply)
   a. BAC ☐
   b. Consumption questions ☐
   c. AUDIT ☐
   d. CAGE ☐
   e. CRAFFT ☐
   f. Other ☐
   • If 'BAC' was selected, please enter cutoff score: __________
   • If 'Consumption' was selected, please enter cutoff score: __________
   • If 'AUDIT' was selected, please enter cutoff score: __________
   • If 'CAGE' was selected, please enter cutoff score: __________
   • If 'CRAFFT' was selected, please enter cutoff score: __________
   • If 'Other', please describe: __________________________________________
7. How do you track compliance with screening of all injured trauma patients?

8. Have all patients who have screened positive received an intervention by an appropriately trained staff, and is this documented? (CD 18-4) Type II / L1-2

☐ Yes ☐ No ☐ N/A Level III

9. Is there a lead person from the trauma program overseeing 'alcohol screening and brief intervention'?

☐ Yes ☐ No

a. Who is the lead for SBI?

b. Have job description available at the time of the site visit as attachment 18-2.

10. What is the mechanism for providing brief intervention? (Check all that apply)

a. Positive screens are referred to trauma nurse/nurse practitioner/physician assistant/social worker: ☐

b. Person screening provides intervention for positive screens: ☐

c. Positive screens are referred to on-site consult service (psychiatry or psychology or substance abuse counselor): ☐

d. Other (if other, please describe): ____________________________

11. How do you track compliance with interventions for all patients who screen positive?

12. List and briefly summarize at least two injury prevention programs that address one of the major causes of injury in the community: (CD 18–5) Type II / L1-2

☐ N/A Level III

- Have injury prevention program information available at the time of the site visit as attachment 18-3.

13. Does the trauma center's prevention program include and track partnerships with other community organizations? (CD 18–6) Type II / L1-2

☐ Yes ☐ No ☐ N/A Level III

- Provide a list of partnership organizations for injury prevention:
14. Does the trauma registry identify injury prevention priorities that are appropriate for local implementation? (CD 15–4) Type II / L1-3

☐ Yes ☐ No

**XIX. RESEARCH**

1. Is there a trauma research program? ☐ Yes ☐ No ☐ N/A Level II or III*

*While not required, if Level II or III may report and research participation

2. Does the administration of a Level I trauma center demonstrate support for the [trauma] research program, for example, providing basic laboratory space, sophisticated research equipment, advanced information systems, biostatistical support, salary support for basic and translational scientists, or seed grants for less experienced faculty? (CD 19-8, CD 10-10, CD 10-11) Type II / LI

☐ Yes ☐ No

- If ‘Yes’, please describe:

3. What is the number of ongoing research projects with IRB approval?

- LIST of ongoing trauma research projects with IRB approval:

4. Does the hospital have any trauma-related grants?

☐ Yes ☐ No

a. If ‘Yes’, how many?

b. LIST of trauma-related research grants:

5. Does the Level I trauma center, at a minimum, have 20 peer-reviewed articles published in journals included
in the Index Medicus or PubMed in a 3-year period? (CD 19–1, CD 10-10, CD 10-11) Type II / LI

☐ Yes  ☐ No

- LIST of trauma-related research publications:

- Please ensure the Summary Form for Research Articles is attached to each article and available on site during the visit.

6. Are these publications a result from work related to trauma center or the trauma system in which the trauma center participates? (CD 19-2, CD 19-3, CD 10-10, CD 10-11) Type II / LI

☐ Yes  ☐ No

- If 'No', please describe:

7. Of the 20 articles, is at least one authored or co-authored by members of the general surgery trauma team? (CD19-3, CD10-10, CD10-11) Type II / LI

☐ Yes  ☐ No

8. At least one article each from three of the following disciplines is required: (1) basic sciences, (2) neurosurgery, (3) emergency medicine, (4) orthopaedics, (5) radiology, (6) anesthesia, (7) vascular surgery, (8) plastics/maxillofacial surgery, (9) critical care, (10) cardiothoracic surgery, (11) rehabilitation, and (12) nursing (CD 19–4, CD 10-10, CD 10-11) Type II / LI

Which disciplines had authorship or co-authorship of at least one of the 20 (or 10) articles? (Check all that apply)

1. Basic Sciences ☐
2. Neurosurgery ☐
3. Emergency Medicine ☐
4. Orthopaedics ☐
5. Radiology ☐
6. Anesthesia ☐
7. Vascular Surgery ☐
8. Plastics/Maxillofacial Surgery ☐
9. Critical Care ☐
10. Cardiothoracic Surgery ☐
11. Rehabilitation ☐
12. Nursing ☐

9. Of the 20 articles (10 articles if 4 of 7 scholarly activities are demonstrated), is there at least 1 article with authorship or co-authorship from 3 of these 6 disciplines? neurosurgery, emergency medicine, orthopaedics, radiology, anesthesia, and rehabilitation (CD 19-7, CD 10-10, CD 10-11) Type II / LI

☐ Yes  ☐ No

10. If the trauma program is pursuing the alternate method of satisfying the research requirement (10 peer-
reviewed articles and 4 of 7 trauma-related scholarly activities), please demonstrate how at least four of the seven scholarly activities listed below has been satisfied: (CD 19-7, CD 10-10, CD 10-11) Type II / LI

1. Leadership in major trauma organizations: ☐
2. Peer-reviewed funding for trauma research: ☐
3. Evidence of dissemination of knowledge: ☐
4. Published trauma-related case reports: ☐
5. Visiting professorships or invited lectures: ☐
6. Resident participation in scholarly activity: ☐
7. Trauma, critical care, or acute surgery fellowship: ☐

XX. DISASTER PLANNING

1. Can the hospital respond to the following hazardous materials?
   a. Radioactive ☐ Yes ☐ No
   b. Chemical ☐ Yes ☐ No
   c. Biological ☐ Yes ☐ No

2. Does the hospital meet the disaster-related requirements of JCAHO or equivalent? (CD 20-1) Type II / L1-3
   ☐ Yes ☐ No

3. Is a trauma panel surgeon a member of the hospital's disaster committee? (CD 20-2) Type II / L1-3
   ☐ Yes ☐ No

4. Are there hospital drills that test the hospital's disaster plan conducted at least twice a year, including actual plan activations that can substitute for drills? (CD 20–3) Type II / L1-3
   ☐ Yes ☐ No
   a. Is there at least one drill of the notification system? ☐ Yes ☐ No
   b. Is there at least one drill with an influx of patients? ☐ Yes ☐ No
   c. Is there at least one drill that involves the community plan? ☐ Yes ☐ No
   d. Is there an action review of your drills ☐ Yes ☐ No

5. Does the trauma center have a hospital disaster plan described in the hospital's policy and procedure manual or equivalent? (CD 20-4) Type II / L1-3
   ☐ Yes ☐ No

XXI. SOLID ORGAN PROCUREMENT

1. Does the facility have a solid organ procurement program?
   ☐ Yes ☐ No
   • If 'Yes', how many trauma referrals were made to the regional organ procurement organization the reporting year? ________________

2. How many trauma patient donors in the reporting year? ________________
   • Number of donations from meeting brain death criteria and after cardiac death (excluding eyes and skin): ________________

3. Does the trauma center have an established relationship with a recognized OPO? (CD 21-1) Type II / L1-3
4. Are there written policies for triggering notification of the OPO? (CD 21-2) Type II / L1-3
   □ Yes  □ No

5. Does the PIPS process review the solid organ donation rate annually? (CD 16-9) Type II / L1-3
   □ Yes  □ No
   • The number of trauma deaths vs. number of organ donation referrals vs successful donations:

6. Are there written protocols defining the clinical criteria and confirmatory tests for the diagnosis of brain death? (CD 21–3) Type II / L1-3
   □ Yes  □ No
   • Briefly describe the protocols and who is privileged to declare brain death: