

Level IV Trauma Center

Designation Criteria for Level IV Trauma Center

Criteria for designation of Level IV Trauma Centers are based upon Resources for Optimal Care of the Injured Patient, COT/American College of Surgeons, 2006. Criteria to verify the services and systems are in place to ensure optimal care of the trauma patient are defined in that document. The following elements must be met for designation as a Level IV Trauma Center in Idaho.

Type I criteria must be in place at the time of the verification site visit to achieve designation. Type II criteria are also required but are less critical. If three or fewer Type II deficiencies are present at the time of the site visit and no Type I criteria are cited, a 1-year certificate of designation is issued. During the following 12 months, if the trauma center successfully corrects the deficiencies, the period of designation will be extended to 3 years from the date of the initial verification visit.

If any Type I deficiency or more than three Type II deficiencies are present at the time of the initial verification site visit, the hospital may not be designated.

| 1. Trauma System | |
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| Time Sensitive Emergencies (TSE) | |
| 1.1 The center is involved in regional trauma system planning, development, and operation. | I |
| Center Mission | |
| 1.2 There is a current resolution supporting the trauma center from the medical staff. | I |
| 1.3 There is a current resolution supporting the trauma center from the hospital board. | I |
| 1.4 There is sufficient infrastructure, staff, equipment, and support to the trauma program to provide adequate provision of care. | I |
| 2. Description of Trauma Center | |
| Description of the Trauma Center | |
| 2.1 The trauma program is empowered to address issues that involve multiple disciplines. | I |
| 2.2 Center provides initial resuscitation of the trauma patient and immediate intervention to control hemorrhage and to assure maximum stabilization prior to referral to an appropriate higher level of care. | I |
| Trauma Leadership | |
| Trauma Medical Director | |
| 2.3 The trauma program has a Trauma Medical Director with the authority and administrative support to lead the program. | I |
| 2.4 The Trauma Medical Director is current in ATLS. | I |
| 2.5 The Trauma Medical Director maintains personal involvement in patient care, staff education, and professional organizations. | I |

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| 2.6 The Trauma Medical Director must work with midlevel providers to ensure appropriate orientation, credentialing, and skill maintenance. | II |
| 2.7 The Trauma Medical Director is responsible for developing and directing the quality improvement program. | I |
| 2.8 The Trauma Medical Director is accountable for all trauma care and exercises administrative authority for the trauma program. | I |
| 2.9 The Trauma Medical Director participates in the internal trauma Quality Improvement (QI) process by attending at least 50% of meetings. | I |
| Trauma Program Manager | |
| 2.10 The center has a Trauma Program Manager. The Trauma Program Manager shows evidence of educational preparation and clinical experience caring for injured patients. | I |
| 2.11 The Trauma Program Manager is responsible for the use of trauma registry data for quality improvement and trauma education. | I |
| 2.12 The Trauma Program Manager works with the Trauma Medical Director to address the multidisciplinary needs of the trauma program. | I |
| 2.13 The Trauma Program Manager serves as a liaison to local Emergency Medical Services (EMS) agencies and accepting centers. | I |
| 3. Clinical Functions | |
| 3.1 The criteria for graded activation must be clearly defined by the center, with the highest level of activation including the six required criteria listed in Table 1. | II |
| 3.2 At minimum, the six criteria listed in Table 1 to be included in the highest level of activation in all trauma centers. | II |
| 3.3 The center must be able to provide the necessary human and physical resources to properly administer acute care consistent with ATLS. | I |
| 3.4 The center must have written protocols outlining which types of trauma patients the facility is capable of providing inpatient services. | I |
| 3.5 The center has established protocols to ensure immediate and appropriate care of the adult and pediatric trauma patient. | I |
| Trauma Team | |
| 3.6 Criteria for all levels of Trauma Team activation (TTA) must be defined and reviewed annually. See table 1 for minimum acceptable criteria. | II |
| 3.7 All trauma/general surgeons, emergency providers, and midlevel providers on the Trauma Team have completed Advanced Trauma Life Support (ATLS) at least once. | II |
| 3.8 Trauma team members participate in multi-disciplinary trauma committee and the quality improvement process. | I |
| 3.9 Trauma Team physicians and midlevel providers are credentialed by the medical staff and governing board. | I |

| Emergency Department (ED) | |
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| 3.10 The physician or midlevel provider will be in the emergency department (ED) on patient arrival for the highest level of activation, provided there is adequate notification from the prehospital providers. The maximum acceptable response time is 30 minutes from patient arrival in the ED. The Process Improvement and Patient Safety (PIPS) program must demonstrate that the provider's presence is in compliance at least 80% of the time. | I |
| 3.11 The center must have emergency coverage by a physician or midlevel provider 24/7. | I |
| 3.12 ED providers must have completed ATLS at least once. | II |
| 3.13 Midlevel providers who participate in the initial evaluation of trauma patients must maintain current ATLS certification. | II |
| Collaborative Clinical Services | |
| Radiology | |
| 3.14 Conventional radiology services (non-CT) must be available 24/7. | I |
| Laboratory | |
| 3.15 Laboratory services are available 24/7 for the standard analysis of blood, urine, and other body fluids, including microsampling when appropriate. | I |
| 3.16 The blood bank must be capable of blood typing and cross-matching. | I |
| 3.17 The center must have a transfusion protocol developed collaboratively between the trauma service and the blood bank. | I |
| Nutrition | |
| 3.18 Nutrition support services are available. | II |
| Social Services | |
| 3.19 The hospital has social services. | I |
| 3.20 The center must screen all trauma patients for alcohol misuse and provide referral resources if appropriate. | II |
| 4. Prehospital Trauma Care | |
| 4.1 The trauma program participates in prehospital care protocol development. | II |
| 5. Interhospital Transfer | |
| 5.1 There are transfer agreements in place with higher level trauma centers as well as specialty referral centers (e.g. burn, pediatric, and rehabilitation centers). | I |
| 5.2 A mechanism for direct physician-to-physician contact is present for arranging patient transfer. | I |
| 5.3 Centers that refer burn patients to a designated burn center must have in place written transfer protocols with a referral burn center. | II |
| 5.4 The center must have guidelines addressing which patients (including pediatric patients) should be transferred and the safe transport of those patients. | I |

6. Process Improvement and Patient Safety (PIPS)

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| 6.1 The center must have a PIPS program to ensure optimal care and continuous improvement of care. | I |
| 6.2 The PIPS program is supported by a reliable method of internal data collection that consistently gathers valid and objective information necessary to analyze and identify opportunities for improvement. | II |
| 6.3 System and process issues (such as documentation and communication), clinical care issues (including identification and treatment of immediate life-threatening injuries), and transfer decisions must be reviewed by the PIPS program. | I |
| 6.4 The trauma program must use evidence-based clinical practice guidelines and protocols. | II |
| 6.5 All process and outcome measures must be documented in a written PIPS plan and updated annually. | II |
| 6.6 The process of analysis occurs at regular intervals to meet the needs of the program. | I |
| 6.7 The process demonstrates problem resolution (loop closure). | I |
| 6.8 The center is able to separately identify the trauma patient population for review. | I |
| 6.9 The PIPS program must have audit filters to review and improve pediatric and adult patient care. | II |
| 6.10 The center uses the registry to support its PIPS program. | I |
| 6.11 Deaths are categorized as unanticipated mortality with opportunity for improvement, anticipated mortality with opportunity for improvement, or mortality without opportunity for improvement. | I |
| 6.12 The PIPS program reviews the organ donation rate. | II |
| 6.13 The PIPS program has defined conditions requiring the surgeon's immediate hospital presence if available. | I |
| 6.14 The PIPS program ensures that the Post-Anesthesia Care Unit (PACU) has the necessary equipment to monitor and resuscitate patients if available. | I |
| 6.15 All Trauma Team activations must be categorized by the priority of response and quantified by number and percentage. | II |
| 6.16 The center's PIPS program must work with receiving facilities to provide and obtain feedback on all transferred patients. | I |
| 6.17 The PIPS program evaluates OR availability and delays when an available on-call team is used. | II |
| 6.18 If available, delays in trauma surgeon response time must be monitored and reviewed for cause of delay and opportunities for improvement. Corrective actions must be documented. | II |
| 6.19 Programs that admit (inpatient or observation) more than 10% of injured patients to nonsurgical services demonstrate the appropriateness of that practice through the PIPS program. | I |

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| 6.20 The adult trauma center that treats children reviews the care of injured children through the PIPS program. | II |
| 6.21 In centers with Intensive Care Units (ICU), transfers to a higher level of care must be reviewed to determine the rationale for transfer, adverse outcomes, and opportunities for improvement. | II |
| 6.22 If the center has an ICU, the PIPS program must document that timely and appropriate care and coverage are being provided. | II |
| 6.23 The center must perform a PIPS review of all admissions and transfers. | I |
| 6.24 The center must have a policy to notify dispatch and Emergency Medical Services (EMS) agencies when on divert status. | I |
| 6.25 The center must have a diversion policy and track the occurrence of diversion through the PIPS program. | II |
| 7. Trauma Program Operational Process Performance Committee (TPOPPC) | |
| 7.1 There is a TPOPPC. This multidisciplinary committee addresses, assesses, and corrects global trauma program and system issues. This committee handles process, includes all program-related services, meets regularly, takes and requires attendance of medical staff involved in trauma care, has minutes, and works to correct all overall program deficiencies to continue to optimize patient care. | I |
| 8. Time Sensitive Emergency (TSE) Registry | |
| 8.1 Data is submitted to the Idaho TSE Registry (Idaho Trauma Registry). At least 80% of cases must be entered into the registry within 180 days of treatment. | I |
| 8.2 There is a process in place to verify that TSE Registry data is accurate and valid. | I |
| 8.3 The trauma program ensures that registry data confidentiality measures are in place. | I |
| 9. Outreach & Education | |
| 9.1 The center must provide annual trauma and injury prevention related public and professional education. | II |
| 10. Prevention | |
| 10.1 The center participates in traumatic injury prevention and bases activities on local data. It is recommended to have a fall prevention program, but not required. | I |
| 10.2 The center must have someone in a leadership position that has injury prevention as part of his or her job description. | II |
| 11. Disaster Planning and Management | |
| 11.1 The center meets the disaster-related National Incident Management System. | I |
| 11.2 The Trauma Medical Director is a member of the center's disaster committee. | I |
| 11.3 The center must participate in regional disaster management plans and exercises. | II |
| 11.4 The center has a disaster plan described in its Disaster Manual. | II |
| 12. Organ Procurement | |
| 12.1 The center has written protocols for declaration of brain death. | II |

| Table 1. Minimum Criteria for Full Trauma Team Activation |
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| Confirmed blood pressure less than 90 mm Hg at any time in adults and age-specific hypotension in children; |
| Gunshot wounds to the neck, chest, or abdomen or extremities proximal to the elbow/knee; |
| Glasgow Coma Scale score less than 9 with mechanism attributed to trauma; |
| Transfer patients from other hospitals receiving blood to maintain vital signs; |
| Intubated patients transferred from the scene; OR |
| Patients who have respiratory compromise or are in need of emergent airway; |
| Included intubated patients who are transferred from another facility with ongoing respiratory compromise (does not include patients intubated at another facility who are now stable from a respiratory standpoint); and |
| Emergency physician's discretion. |