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| **DEPARTMENT OF HEALTH SERVICES**Division of Public HealthF-47484 (07/2023) | **STATE OF WISCONSIN** Trauma Program |
| **LEVEL III****PRE-REVIEW QUESTIONNAIRE (PRQ)** |
| This PRQ allows site reviewers to have a preliminary understanding of the trauma care capabilities and performance of the hospital and medical staff before beginning the review. Please use this document to gather the hospital data. Please note, the site review team **may** ask for further documentation to substantiate information on any question that is answered.Complete each section of the PRQ and attach additional pages if necessary. Ensure all attachments are included and labeled appropriately. Submit the PRQ no later than 45 days prior to the scheduled site visit. Keep a copy of the PRQ for reference during the site visit.The information used to complete the site review report will be considered in the classification determination. The reporting period is defined as 12 months and cannot be earlier than 15 months prior to the submission of the PRQ. At a minimum, there must be 12 months of data in the State Trauma Registry to schedule a site review. Ongoing data submission (quarterly) is a requirement for classification.Submit the PRQ, the facility’s **trauma activation criteria, written PIPS plan and job descriptions for the trauma medical director and trauma program manager** via email to the DHS Trauma Program, DHSTrauma@dhs.wisconsin.gov. If you have questions about the PRQ, the site visit, or the trauma system, please contact the DHS Trauma via email, the State Trauma Program Coordinator will contact you as soon as possible. The State Trauma Program Coordinator will email receipt confirmation when the PRQ is received.**Please answer all questions completely**. Do not use abbreviations. You may also be asked about any of the questions at the site review. |
| **Type of Review:** | [ ]  New Classification [ ]  Reclassification |
| **Reporting time frame**: | From (month/ year)       | To (month/ year)       |
| **Previous Site Review** | Date of review:       |
| 1. Please list the criteria deficiencies identified by the reviewers and how these were resolved.
 |
|       |
| 1. Please list the opportunities for improvement identified by the reviewers, and how you addressed each of them.
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|       |
| **HOSPITAL INFORMATION - DEMOGRAPHICS** |
| Name of Hospital |
|       |
| Hospital Address | City | Zip | Trauma Region |
|       |       |       |       |
| **General Information** |
| Trauma Manager - Name | Contact Information (email and phone) |
|       |       |       |
| Trauma Coordinator - Name | Contact Information (email and phone) |
|       |       |       |
| Trauma Medical Director - Name |
|       |
| Trauma Registrar - Name(s) |
|       |
|       |
| Injury Prevention Staff - Name |
|       |
| Other: |
|       |
| **Table One** |
| **Trauma Care Provider** | **Total Number of Providers** |
| Emergency Department Physicians |       |
| Emergency Department Advance Practice Providers  |       |
| General Surgeons taking trauma call |       |
| Orthopedic Surgeons |       |
| Neurosurgeons |       |
| Anesthesiologists |       |
| Certified Registered Nurse Anesthetists (CRNA) |       |
| **Trauma/ Hospital Statistical Data** (using data from reporting year please complete the following) |
| **Table Two** |
| **Patients** | **Number** |
| Entered into Trauma Registry |       |
| Highest Level Trauma Activation |       |
| Discharged Alive From ED |       |
| Discharged as Deceased from ED |       |
| Transferred |       |
| Admitted to your facility (inpatient, short stay, observation) |       |
| **Table Three** |
| **Number of Trauma Transfers** | **Air** | **Ground** | **Private Vehicle** | **Total** |
| Transfers In |       |       |       |       |
| Transfers Out |       |       |       |       |
| **Table Four** |
| **Trauma Admissions by Service** | **Number of Admissions** |
| General/ Trauma Surgery |       |
| Orthopedic Surgery |       |
| Neurosurgery |       |
| Other Surgical Subspecialties |       |
| Non-Surgical |       |
| Total Admissions |       |
|  |
| **Injury Severity Score/ Mortality for admissions to inpatient, observation, short stay:** |
| **Table Five** |
| **ISS** | **Total Number of Admissions** | **Number of Deaths after Admission (includes observation status)** | **Number Admitted to a Surgical Service** |
| 0-9 |       |       |       |
| 10-15 |       |       |       |
| 16-24 |       |       |       |
| 25 and greater |       |       |       |
| Total |       |       |       |
| **STANDARDS for Level III Trauma Care Facilities (TCF)** |
| **1 - Trauma Care Systems** |
|  | **Level** | **Criterion** | **Type** |
| 1(a) | III | TCFs and their health care providers must be active and engaged participants in the trauma care system and promote standardization, integration, and PIPS throughout the region and state. TCFs must be involved in state and regional trauma care system planning, development and operation and actively participate in regional and statewide trauma care system meetings and committees that provide oversight. The TPM, TMD or trauma registrar must attend at least 50% of the TCF’s RTAC meetings annually. The TPM, TMD or trauma registrar may not represent more than three TCFs at any one RTAC meeting.  | 2 |
| Does the hospital trauma program staff participate in the state and/or regional trauma system planning, development, or operation? | [ ]  Yes | [ ]  No | % attended       |
| Did the TPM, TMD or trauma registrar represent more than three TCFs at any one RTAC meeting in the reporting year? | [ ]  Yes | [ ]  No |  |
| **2 - Description of Trauma Care Facilities and Their Roles in a Trauma Care System** |
|  | **Level** | **Criterion** | **Type** |
| 2(a) | III | The TCF must have an integrated, concurrent trauma PIPS program. | 1 |
| Describe your PIPS program and processes.      |
|  | **Level** | **Criterion** | **Type** |
| 2(b) | III | The TCF must have surgical commitment. | 1 |
| Is a surgeon the director of the trauma program? | [ ]  Yes | [ ]  No |
| Do surgeons take an active role in all aspects of care of injured patients? | [ ]  Yes | [ ]  No |
| Are surgeons involved in the trauma PIPS program? | [ ]  Yes | [ ]  No |
|  | **Level** | **Criterion** | **Type** |
| 2(c) | III | The TCF must be able to provide the necessary human and physical resources including the physical plant and equipment as well as policies and procedures to properly administer acute care for all ages, consistent with their level of classification.  | 2 |
| Does this facility have the necessary physical plant, equipment, and policies and procedures to properly administer acute care of all ages and consistent with the level of classification? | [ ]  Yes | [ ]  No |
|  | **Level** | **Criterion** | **Type** |
| 2(d) | III | To care for adult patients, the TCF must have emergency departmentpolicies, procedures, protocols, or guidelines.  | 2 |
| Does the facility have ED policies, procedures, protocols or guidelines (Example: sedation and analgesia, injury imaging, dosing for meds)? | [ ]  Yes | [ ]  No |
| Please list 3 of your policies, procedures, protocols or guidelines:                |
|  | **Level** | **Criterion** | **Type** |
| 2(e) | III | The TCF must have medications and equipment readily available for emergency care. | 2 |
| Does the TCF have the following medications and equipment readily available? |
| (1) Airway control and ventilation | [ ]  Yes | [ ]  No |
| (2) Pulse oximetry | [ ]  Yes | [ ]  No |
| (3) End tidal carbon dioxide determination | [ ]  Yes | [ ]  No |
| (4) Suction | [ ]  Yes | [ ]  No |
| (5) Electrocardiogram monitoring or defibrillation | [ ]  Yes | [ ]  No |
| (6) Fluid administration such as standard intravenous therapy or large-bore administration devices and catheters | [ ]  Yes | [ ]  No |
| (7) Cricothyrotomy | [ ]  Yes | [ ]  No |
| (8) Thoracostomy | [ ]  Yes | [ ]  No |
| (9) Vascular access | [ ]  Yes | [ ]  No |
| (10) Decompression | [ ]  Yes | [ ]  No |
| (11) Gastric decompression | [ ]  Yes | [ ]  No |
| (12) Conventional radiology | [ ]  Yes | [ ]  No |
| (13) Two-way radio communication with ambulance crew or rescue | [ ]  Yes | [ ]  No |
| (14) Skeletal and cervical immobilization | [ ]  Yes | [ ]  No |
| (15) Thermal control for patients and resuscitation fluids | [ ]  Yes | [ ]  No |
| (16) Rapid fluid infusion | [ ]  Yes | [ ]  No |
|  | **Level** | **Criterion** | **Type** |
| 2(f) | III | It is expected that the surgeon will be in the emergency department on patient arrival with adequate notification from the field. The maximum acceptable surgeon response time, with notification from the field and tracked from patient arrival, is 30 minutes for the highest level activation. The surgeon must be activated for all highest level activations regardless of impending transfer or other scenario.Note: for TCFs with less than six highest-level activations annually, surgeon response time may be tracked over 3 years. | 1 |
| What is the percent of time that the surgeon is present in the ED within 30 minutes of patient arrival for the highest level of activation? |      % |
| Is the surgeon activated for all highest levels of activations regardless of impending transfer or other scenario? | [ ]  Yes | [ ]  No |
| Is surgeon response time documented in the medical record? | [ ]  Yes | [ ]  No |
| Are all activations and response times reviewed in the trauma PIPS program?  | [ ]  Yes | [ ]  No |
|  | **Level** | **Criterion** | **Type** |
| 2(h) | III | The TCF must have continuous general surgical coverage. The TCF musthave a back-up plan in place for when a surgeon is not available. Theback-up plan may include activation of a back-up surgeon or transfer ofthe patient. A surgeon may be on-call at more than one TCF but eachTCF must have a back-up plan.The TCF must monitor all the times that a surgeon is unable to respondthrough the trauma PIPS program. | 2 |
| Is there a back-up plan in place for when a surgeon is not available?  | [ ]  Yes | [ ]  No |  |
| Is the surgeon on call at more than one TCF? | [ ]  Yes | [ ]  No |  |
| Does the trauma PIPS program monitor all times when a surgeon is unable to respond?  | [ ]  Yes | [ ]  No |  |
|  | **Level** | **Criterion** | **Type** |
| 2(i) | III | The TCF must have transfer plans that include a plan for expeditiouscritical care transport, follow-up and performance monitoring. | 2 |
| Are there transfer plans that include expeditious critical care transport, follow-up and performance monitoring? | [ ]  Yes | [ ]  No |  |
| Please be ready to discuss these plans at the site review. For example, what critical care transport do you use, where do you transfer ortho patients, neurosurgery patients, etc. |
|  | **Level** | **Criterion** | **Type** |
| 2(n) | III | A TMD and TPM knowledgeable and involved in trauma care must worktogether with guidance from the trauma multidisciplinary peer reviewcommittee to identify events, develop corrective action plans and ensuremethods of monitoring, reevaluating and benchmarking. | 2 |
| Does the trauma multidisciplinary peer review committee work with the TMD and TPM to identify events, develop corrective action plans and ensure monitoring? | [ ]  Yes | [ ]  No |  |
|  | **Level** | **Criterion** | **Type** |
| 2(o) | III | The trauma multidisciplinary peer review committee must:(1) Meet at least quarterly to ensure cases are being reviewed in a timely fashion.(2) Review systemic and care provider issues and propose improvements to the care of the injured patient.(3) Include the TPM, TMD and other key staff and departments involved with care of the trauma patient as members of the committee.(4) Have representation from general surgery, including all general surgeons taking trauma call.(5) Have liaisons from emergency medicine, orthopedics, anesthesiology, critical care and the ICU.(6) Have liaisons from all the specialty care services, such as neurosurgery and radiology, provided by the TCF.(7) Require 50% attendance of its continuous members and document attendance.(8) Systematically review mortalities, significant complications and process variances associated with unanticipated outcomes and determine opportunities for improvement, as evidenced by documented meeting minutes.(9) Review selected cases involving multiple specialties, mortality data, adverse events and problem trends.If a designated liaison is unable to attend, another representative from thesame service team may participate in their place. The TCF may determinewhich members of the trauma multidisciplinary peer review committeeare continuous versus ad-hoc. | 2 |
| Does the multidisciplinary peer review committee: |
| Meet at least quarterly to ensure cases are being reviewed in a timely fashion? | [ ]  Yes | [ ]  No |  |
| Review systemic and care provider issues and propose improvements to the care of the injured patient? | [ ]  Yes | [ ]  No |  |
| Include the TPM, TMD and other key staff and departments involved with care of the trauma patient as members of the committee? | [ ]  Yes | [ ]  No |  |
| Have representation from general surgery, including all general surgeons taking trauma call if participating in the trauma program? | [ ]  Yes | [ ]  No |  |
| Have liaisons from emergency medicine, orthopedics, anesthesiology, critical care and the ICU if provided at the TCF? | [ ]  Yes | [ ]  No |  |
| Have liaisons from all the specialty care services, such as neurosurgery and radiology, provided by the TCF? | [ ]  Yes | [ ]  No |  |
| Require 50% attendance of its continuous members and document attendance? | [ ]  Yes | [ ]  No |  |
| Systematically review mortalities, significant complications and process variances associated with unanticipated outcomes and determine opportunities for improvement, as evidenced be documented meeting minutes? | [ ]  Yes | [ ]  No |  |
| Review selected cases involving multiple specialties, mortality data, adverse events and problem trends? | [ ]  Yes | [ ]  No |  |
|  | **Level** | **Criterion** | **Type** |
| 2(p) | III | The TCF’s trauma PIPS program must have audit filters to review and improve pediatric and adult patient care. | 2 |
| Does the PIPS program have audit filters for adult care?  | [ ]  Yes | [ ]  No |  |
| Does the PIPS program have audit filters for pediatric care? | [ ]  Yes | [ ]  No |  |
|  | **Level** | **Criterion** | **Type** |
| 2(q) | III | If an adult TCF annually admits 100 or more injured patients younger than 15 years old, the TCF must:(1) Have trauma surgeons credentialed for pediatric trauma care by the facility’s credentialing body.(2) Have a pediatric emergency department area.(3) Have a pediatric intensive care area.(4) Have appropriate resuscitation equipment.(5) Have a pediatric-specific trauma PIPS program. | 2 |
| Does this facility annually admit 100 or more injured patients younger than 15 years old?  | [ ]  Yes | [ ]  No |  |
| If yes, does this facility: |
| Have trauma surgeons credentialed for pediatric trauma care by the facility’s credentialing body? | [ ]  Yes | [ ]  No | [ ] N/A |
| Have a pediatric emergency department area? | [ ]  Yes | [ ]  No | [ ] N/A |
| Have a pediatric intensive care area? | [ ]  Yes | [ ]  No | [ ] N/A |
| Have appropriate resuscitation equipment | [ ]  Yes | [ ]  No | [ ] N/A |
| Have a pediatric-specific trauma PIPS program? | [ ]  Yes | [ ]  No | [ ] N/A |
|  | **Level** | **Criterion** | **Type** |
| 2(r) | III | If an adult TCF annually admits fewer than 100 injured patients younger than 15 years old, the TCF must review the care of injured children as part of the trauma PIPS program. This review must include pediatric admissions and transfers. | 2 |
| Does this facility review all pediatric admissions and transfers? | [ ]  Yes | [ ]  No |  |
| **3 - Prehospital Trauma Care** |
| Briefly describe EMS services in your area, including transport services:       |
|  | **Level** | **Criterion** | **Type** |
| 3(a) | III | The TCF must participate in the training of prehospital care providers, the development and improvement of prehospital care protocols and the prehospital PIPS program. The TCF must review care and provide feedback to prehospital care providers.The TCF can participate in the training of prehospital care providers in a variety of ways including being involved in programs such as Prehospital Trauma Life Support (PHTLS), grand rounds, trauma conferences, and case reviews. | 2 |
| Does the facility participate in: |
| Training of prehospital care providers? | [ ]  Yes | [ ]  No |  |
| Development and improvement of prehospital care protocols? | [ ]  Yes | [ ]  No |  |
| Prehospital PIPS program? | [ ]  Yes | [ ]  No |  |
| Does the facility review care and provide feedback to prehospital care service? | [ ]  Yes | [ ]  No |  |
| Please describe the review and feedback process:       |
|  | **Level** | **Criterion** | **Type** |
| 3(b) | III | The trauma health care team, including surgeons, emergency medicine physicians, medical directors for EMS agencies and basic and advanced prehospital personnel must actively participate in the development of protocols that guide prehospital care. | 2 |
| Does the hospital actively participate in the development of protocols that guide prehospital care? | [ ]  Yes | [ ]  No |  |
| If “No”, please explain:      |
|  | **Level** | **Criterion** | **Type** |
| 3(c) | III | TCFs must evaluate over and under triage rates on a quarterly basis and perform rigorous multidisciplinary performance improvement to attain a goal of less than five percent under triage. If a TCF is not meeting this goal, the TCF must explain the variance and demonstrate that they are doing performance improvement work to reach this goal. | 2 |
| What is your under triage rate? |      % |  |
| What is your over triage rate? |      % |  |
| If the under triage rate is greater than 5%, explain the variance and work done to improve the goal:      |
|  | **Level** | **Criterion** | **Type** |
| 3(d) | III | A TCF must have a diversion protocol for trauma related occurrences, which includes a system to notify dispatch and EMS agencies. | 2 |
| Do you have a diversion protocol for trauma related occurrences? | [ ]  Yes | [ ]  No |  |
|  | **Level** | **Criterion** | **Type** |
| 3(e) | III  | The TMD must be involved in the development of the TCF’s diversion protocol for trauma related occurrences. | 2 |
| Was the TMD involved in the development of the diversion protocol? | [ ]  Yes | [ ]  No |  |
|  | **Level** | **Criterion** | **Type** |
| 3(f) | III  | A trauma surgeon must be involved in the decision each time the TCF goes on diversion for trauma related occurrences. | 2 |
| Is a trauma surgeon involved in the decision each time you go on diversion? | [ ]  Yes | [ ]  No |  |
|  | **Level** | **Criterion** | **Type** |
| 3(g) | III  | A TCF must not be on diversion for trauma related occurrences more than five percent of the time. | 2 |
| What percent of the time were you on diversion during the reporting year? |      % |  |
|  | **Level** | **Criterion** | **Type** |
| 3(h) | III  | When a TCF is required to divert for trauma related occurrences it must:(1) Notify other TCFs of divert or advisory status.(2) Maintain a divert log.(3) Review all diverts and advisories to the trauma PIPS program. | 2 |
| Explain the diversion process:       |
|  | **Level** | **Criterion** | **Type** |
| 3(i) | III  | The TCF must routinely document, report and monitor their diversion hours. This documentation must include the reason for initiating the diversion policy. | 2 |
| Explain how diversions are documented, reported and monitored:      |
| **4 - Inter-Hospital Transfer** |
|  | **Level** | **Criterion** | **Type** |
| 4(a) | III | When transferring a patient direct provider-to-provider contact is required.  | 2 |
| When transferring a patient, there is always provider-to-provider contact? | [ ]  Yes | [ ]  No |  |
|  | **Level** | **Criterion** | **Type** |
| 4(b) | III | The TCF’s decision to transfer an injured patient to a specialty care facility in an acute situation must be based solely on the needs of the patient and not on the requirements of the patient’s specific provider network or the patient’s ability to pay. | 2 |
| In an acute situation, is the location to transfer is solely based on patient need? | [ ]  Yes | [ ]  No |  |
|  | **Level** | **Criterion** | **Type** |
| 4(c) | III  | When a patient is being transferred out, the TCF must have a contingency plan that includes:(1) A credentialing process to allow the trauma surgeon or other physician to provide initial evaluation and stabilization of the patient.(2) A requirement for direct contact with the accepting facility to arrange for expeditious transfer or ongoing monitoring support.(3) A review process through the trauma PIPS program to monitor the efficacy of the transfer process. | 2 |
| Is there a contingency plan that includes: |
| A credentialing process to allow the surgeon or physician to provide initial evaluation and stabilization? | [ ]  Yes | [ ]  No |  |
| A requirement of direct contact with the accepting facility to arrange for expeditious transfer or ongoing monitoring support? | [ ]  Yes | [ ]  No |  |
| A review process through the trauma PIPS program to monitor the efficacy of the transfer process? | [ ]  Yes | [ ]  No |  |
|  | **Level** | **Criterion** | **Type** |
| 4(d) | III | The TCF must review all trauma patients who are transferred out during the acute care phase and all trauma patients transferred to a higher level of care within or outside of the TCF to review the rationale for transfer, appropriateness of care, adverse outcomes and opportunities for improvement. This case review should include evaluation of transport activities and follow-up from the TCF to which the patient was transferred. | 2 |
| Are all patients transferred to a higher level of care within the hospital reviewed for appropriateness of care, adverse outcomes and opportunities for improvement | [ ]  Yes | [ ]  No |  |
| Are all trauma patients transferred out during the acute phase, or after admission, reviewed for appropriateness of care, adverse outcomes and opportunities for improvement, including transport activities and follow-up from the accepting facility? | [ ]  Yes | [ ]  No |  |
| **5 - Hospital Organization and the Trauma Program** |

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|  | **Level** | **Criterion** | **Type** |
| 5(a) | III | The decision of a hospital to become a TCF requires the commitment of the institutional governing body and the medical staff, and this administrative commitment must be documented. The TCF must have resolutions from both the institutional governing body and the medical staff acknowledging this commitment, and these resolutions must empower the trauma PIPS program to address events that involve multiple disciplines and to evaluate all aspects of trauma care. | 1 |
| Is there a resolution from the institutional governing body acknowledging their commitment to the trauma program? | [ ]  Yes | [ ]  No |  |
| Is there a resolution from the medical staff acknowledging their commitment to the trauma program? | [ ]  Yes | [ ]  No |  |

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|  | **Level** | **Criterion** | **Type** |
| 5(b) | III | The TCF’s administrative support must be current at the time of the site visit and must be reaffirmed every three years. The administrative support must be from the Board of Directors, Chief Executive Officer or Chief Administrator and the medical staff or medical executive committee. | 2 |
| Are the resolutions current and reaffirmed every three years? | [ ]  Yes | [ ]  No |  |
| Are the resolutions from the appropriate individuals or committees? | [ ]  Yes | [ ]  No |  |

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|  | **Level** | **Criterion** | **Type** |
| 5(c) | III | The trauma program must involve multiple disciplines and transcend normal department hierarchies by having appropriate specialty representation from all phases of care. | 2 |
| Does the trauma program involve multiple disciplines and transcend normal department hierarchies? | [ ]  Yes | [ ]  No |  |

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|  | **Level** | **Criterion** | **Type** |
| 5(d) | III | The TMD must meet one of the following set of standards:(1) Be a current board-certified general surgeon, neurosurgeon or orthopedic surgeon and be actively involved in the care of trauma patients.(2) Be eligible for board certification in general surgery, neurosurgery or orthopedic surgery and be actively involved in the care of trauma patients.(3) Be approved to take trauma call through the alternate pathway requirements for general surgeons, neurosurgeons or orthopedic surgeons and be actively involved in the care of trauma patients.(4) Be a current board certified emergency medicine physician and staff the emergency department.(5) Be eligible for board certification as an emergency medicine physician and staff the emergency department.(6) Be approved to take trauma call through the alternate pathway for emergency medicine physicians and staff the emergency department. | 1 |
| The TMD meets which of the above standards (1-6)?       |

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|  | **Level** | **Criterion** | **Type** |
| 5(e) | III | The TMD must be current in ATLS. | 2 |
| TMD ATLS current expiration date: |       |  |

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|  | **Level** | **Criterion** | **Type** |
| 5(f) | III | The TMD must have the authority to manage all aspects of trauma care. | 2 |
| Does the TMD have the authority to manage all aspects of trauma care? | [ ]  Yes | [ ]  No |  |

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|  | **Level** | **Criterion** | **Type** |
| 5(g) | III  | The TMD may not direct more than two trauma centers. | 2 |
| Does the TMD direct more than this trauma center? | [ ]  Yes | [ ]  No |  |
| If the answer is “yes”, please provide the name(s) and locations:       |

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|  | **Level** | **Criterion** | **Type** |
| 5(h) | III  | The TMD must actively participate in the trauma multidisciplinary PIPS review committee.  | 2 |
| Does the TMD actively participate in the trauma multidisciplinary PIPS review committee? | [ ]  Yes | [ ]  No |  |

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|  | **Level** | **Criterion** | **Type** |
| 5(i) | III  | The TMD, in collaboration with the TPM, must have the responsibility and authority to report any deficiencies in trauma care and any trauma team members who do not meet specified trauma call criteria to the appropriate person(s). | 2 |
| Do the TMD and TPM have the responsibility and authority to report any deficiencies in trauma care and team members who do not meet specified trauma call criteria to the appropriate person(s). | [ ]  Yes | [ ]  No |  |

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|  | **Level** | **Criterion** | **Type** |
| 5(j) | III  | The TMD must conduct, and have the authority to conduct, an annual assessment of the trauma panel providers in the form of Ongoing Professional Practice Evaluation and Focused Professional Practice Evaluation when indicated by findings of the trauma PIPS process. The TMD must have the authority to recommend changes for the trauma panel based on performance review. | 2 |
| Does the TMD conduct an annual assessment of the trauma panel providers? | [ ]  Yes | [ ]  No |  |

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|  | **Level** | **Criterion** | **Type** |
| 5(k) | III  | The TMD and TPM must be granted authority by the hospital governing body to lead the trauma PIPS program. This authority must be evidenced in written job descriptions for both the TMD and TPM. | 1 |
| Do the TMD and TPM have the authority to lead the trauma PIPS program? | [ ]  Yes | [ ]  No |  |

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|  | **Level** | **Criterion** | **Type** |
| 5(l) | III  | The criteria for a graded activation must be clearly defined by the TCF. TCFs must have the highest level of activation. The highest level activation criteria must include the following criteria:(1) Confirmed blood pressure less than 90 millimeters of mercury at any time in adults and delineated by age range hypotension in children.(2) Gunshot wounds to the neck, chest, or abdomen or extremities proximal to the elbow/knee.(3) Glasgow coma scale score less than nine with mechanism attributed to trauma.(4) Transfer patients from other hospitals receiving blood to maintain vital signs.(5) Intubated patients transferred from the scene or patients who have respiratory compromise or are in need of an emergency airway. This includes intubated patients who are transferred from another facility with ongoing respiratory compromise.(6) Emergency medicine physician’s discretion. | 2 |
| Does the TCF have all required criteria in the highest level of activation? | [ ]  Yes | [ ]  No |  |

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|  | **Level** | **Criterion** | **Type** |
| 5(m) | III  | The trauma team, as defined by the TCF, must be fully assembled within 30 minutes of trauma activation.  | 2 |
| Is the trauma team fully assembled within 30 minutes of trauma activation? | [ ]  Yes | [ ]  No |  |

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|  | **Level** | **Criterion** | **Type** |
| 5(n) | III | The TCF’s trauma PIPS program must evaluate on an ongoing basis the potential criteria for the various levels of trauma team activation to determine which patients require the resources of the full trauma team. Variances in trauma team activation must be documented and reviewed for reasons for delay, opportunities for improvement and corrective actions. | 2 |
| Does the trauma PIPS program evaluate activation criteria on an ongoing basis?  | [ ]  Yes | [ ]  No |  |
| Are variances in team activation documented and reviewed for reasons for delay, opportunities for improvement and corrective actions? | [ ]  Yes | [ ]  No |  |

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|  | **Level** | **Criterion** | **Type** |
| 5(o) | III | An emergency medicine physician may initially evaluate the limited-tier trauma patient, but the TCF must have a clearly defined response expectation for the trauma surgical evaluation of those patients requiring admission. | 2 |
| Please provide the defined response expectation for the trauma surgical evaluation of patients requiring admission:       |

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|  | **Level** | **Criterion** | **Type** |
| 5(p) | III | The TCF may admit injured patients to individual surgeons, but the structure of the trauma program must allow the TMD to have oversight authority for the care of these patients. The TCF must have a process for the TMD and TPM to review inpatient cases through the trauma PIPS program. | 2 |
| Does the TMD have oversight authority for the care of admitted patients? | [ ]  Yes | [ ]  No |  |
| Explain the process for the TMD and TPM to review inpatient cases through the PIPS program:      |

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|  | **Level** | **Criterion** | **Type** |
| 5(q) | III | For TCFs that admit injured patients to individual surgeons or nonsurgical services, the TCF must have a method to identify injured patients, monitor the provision of health care services, make periodic rounds and hold discussions with individual practitioners. These activities may be carried out by the TPM in conjunction with the TMD at a frequency commensurate with the volume of trauma admissions. | 1 |
| Is there a method to identify injured patients, monitor provision of health care services, make periodic rounds and hold discussions with the individual practitioners | [ ]  Yes | [ ]  No |  |
| Please explain how this is done:      |

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|  | **Level** | **Criterion** | **Type** |
| 5(r) | III | A TCF must have written guidelines for the care of non-surgically admitted patients. TCFs that admit more than 10% of injured patients to non-surgical services must review all non-surgical admissions through the trauma PIPS program. Care must be reviewed for appropriateness of admission, patient care, complications and outcomes. If a trauma patient is admitted by an internal medicine physician for medical comorbidities or medical management, a surgical consultation is required. | 2 |
| Do you have written guidelines for care of the non-surgically admitted patients? | [ ]  Yes | [ ]  No |  |
| What percent of injured patients are admitted to non-surgical services? |      % |  |
| If greater than 10%, is all care reviewed for appropriateness of admission, patient care, complications and outcomes? | [ ]  Yes | [ ]  No |  |
| Is a surgical consult obtained when a patient is admitted to a non-surgical service?  | [ ]  Yes | [ ]  No |  |
| If “No”, please explain:      |

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|  | **Level** | **Criterion** | **Type** |
| 5(s) | III | The TPM must show evidence of educational preparation, relevant clinical experience in the care of injured patients and administrative ability. The TCF may determine who meets these requirements. Evidence that a TPM meets these requirements may include a copy of the trauma coordinator job description. The TPM may be a nurse, but does not have to be. | 2 |
| How long as the TPM been in this position? | Years      | Months      |  |
| In addition to administrative ability, does the TPM have evidence of educational preparation and clinical experience in the care of injured patients? | [ ]  Yes | [ ]  No |  |
| What trauma education has the TPM received in the last 3 years (TOPIC, trauma coding, trauma CEUs, trauma conferences)?       |

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| **6 - Clinical Functions: General Surgery** |

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|  | **Level** | **Criterion** | **Type** |
| 6(a) | III | The TCF must have continuous general surgery capability. | 1 |
| Is there continuous general surgery capability? | [ ]  Yes | [ ]  No |  |

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|  | **Level** | **Criterion** | **Type** |
| 6(b) | III | General surgeons must meet one of the following set of standards in order to take trauma call:(1) Be board certified by the American Board of Surgery.(2) Be eligible for board certification by the American Board of Surgery according to current criteria.(3) Meet the general surgery alternate pathway requirements in 6.(c);or(4) Have completed an Accreditation Council for Graduate Medical Education or Canadian residency and be recognized by a major professional organization.Note: An example of recognition by a major professional organization isbeing a fellow of the ACS. | 2 |
| Do all general surgeons who take trauma call, meet one of the above standards | [ ]  Yes | [ ]  No |  |

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|  | **Level** | **Criterion** | **Type** |
| 6(c) | III | The alternate pathway requirements for general surgeons are:(1) Completion of a residency training program in general surgery, with the time period consistent with years of training in the United States. The completion of a residency training program must be evidenced by a certified letter from the program director.(2) Current certification as a provider or instructor of the ATLS program.(3) Completion of 36 hours of trauma continuing medical education within the last three years.(4) Attendance at educational meetings and at least 50% of all trauma PIPS meetings in the past three years.(5) Membership or attendance at local and regional or national meetings during the past three years.(6) Provision of a list of patients treated in the last three years with accompanying Injury Severity Score and outcome data.(7) Completion of a performance improvement assessment by the TMD demonstrating that the morbidity and mortality results for patients treated by the surgeon compare favorably with comparable patients treated by other members of the call panel.(8) License to practice medicine and approval for full and unrestricted surgical privileges by the facility’s credentialing committee. | 2 |
| Are there general surgeons in the alternative pathway? | [ ]  Yes | [ ]  No |  |
| If yes, do they meet all criteria? | [ ]  Yes | [ ]  No |  |

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|  | **Level** | **Criterion** | **Type** |
| 6(d) | III | Trauma surgeons in a TCF must have privileges in general surgery. | 2 |
| Do all trauma surgeons have privileges in general surgery? | [ ]  Yes | [ ]  No |  |

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|  | **Level** | **Criterion** | **Type** |
| 6(e) | III | The attending surgeon must be present in the operating room for all operations and the TCF must document the presence of the attending surgeon.  | 2 |
| Is the attending surgeon present in the operating room for all operations? | [ ]  Yes | [ ]  No |  |

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|  | **Level** | **Criterion** | **Type** |
| 6(f) | III | All general surgeons on the trauma team must have successfully completed the ATLS course at least once.  | 2 |
| Have all general surgeons who take trauma call completed ATLS at least once? | [ ]  Yes | [ ]  No |  |

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| **7 - Clinical Functions: Emergency Medicine** |

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|  | **Level** | **Criterion** | **Type** |
| 7(a) | III | The TCF’s emergency department must have a designated emergency physician director supported by an appropriate number of additional physicians to ensure immediate care for injured patients. | 1 |
| Is there a designated physician director of the emergency department? | [ ]  Yes | [ ]  No |  |
| Is there an appropriate number of physicians to ensure immediate care for injured patients? | [ ]  Yes | [ ]  No |  |

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|  | **Level** | **Criterion** | **Type** |
| 7(b) | III | When it is necessary for the physician to leave the emergency department for short periods to address in-house emergencies, these cases and their frequency must be reviewed by the trauma PIPS program for timeliness of response and appropriateness of care and to ensure that this practice does not adversely affect the care of patients in the emergency department. | 2 |
| Does the trauma PIPS program review, for timeliness of responses and appropriateness of care for ED patients, all times that the physician leaves the emergency department for in-house emergencies? | [ ]  Yes | [ ]  No |  |

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|  | **Level** | **Criterion** | **Type** |
| 7(c) | III | For TCFs with an emergency medicine residency training program, supervision must be provided by in-house attending emergency physicians 24 hours per day. | 2 |
| Does your hospital have an emergency medicine residency training program? | [ ]  Yes | [ ]  No |  |
| If yes, is there an in-house attending emergency physician 24/7? | [ ]  Yes | [ ]  No |  |

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|  | **Level** | **Criterion** | **Type** |
| 7(d) | III | Emergency medicine physicians must meet one of the following set of standards in order to take trauma call:(1) Be board certified in emergency medicine.(2) Be eligible for board certification by the appropriate emergency medicine board according to current criteria.(3) Be board certified in a specialty other than emergency medicine recognized by the American Board of Medical Specialties, the American Osteopathic Association, or the Royal College of Physicians and Surgeons of Canada.(4) Meet the emergency medicine alternate pathway requirements; or(5) Have completed an Accreditation Council for Graduate Medical Education or Canadian residency and be recognized by a major professional organization.Note: An example of recognition by a major professional organization isbeing a fellow of the ACS. | 2 |
| Do all emergency medicine physicians meet one of the above standards? | [ ]  Yes | [ ]  No |  |

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|  | **Level** | **Criterion** | **Type** |
| 7(e) | III | The alternate pathway requirements for emergency medicine physicians are:(1) Completion of a residency training program in emergency medicine, with the time period consistent with years of training in the United States. The completion of a residency training program must be evidenced by a certified letter from the program director.(2) Current certification as a provider or instructor of the ATLS program.(3) Completion of 36 hours of trauma continuing medical education within the last three years.(5) Attendance at educational meetings and at least 50% of all trauma PIPS meetings in the past three years.(5) Membership or attendance at local and regional or national meetings during the past three years.(6) Provision of a list of patients treated in the last three years with accompanying Injury Severity Score and outcome data.(7) Completion of a performance improvement assessment by the TMD demonstrating that the morbidity and mortality results for patients treated by the emergency medicine physician compare favorably with comparable patients treated by other members of the call panel.(8) License to practice medicine and approval for full and unrestricted emergency medicine privileges by the facility’s credentialing committee. | 2 |
| Are there emergency medicine physicians in the alternative pathway? | [ ]  Yes | [ ]  No |  |
| If yes, do they meet all criteria? | [ ]  Yes | [ ]  No |  |

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|  | **Level** | **Criterion** | **Type** |
| 7(f) | III | Emergency medicine physicians on the emergency department schedule must be regularly involved in the care of injured patients. | 2 |
| Are all emergency medicine physicians on the schedule regularly involved in the care of injured patients? | [ ]  Yes | [ ]  No |  |

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|  | **Level** | **Criterion** | **Type** |
| 7(g) | III | A representative from the emergency department must participate in the prehospital PIPS program. | 2 |
| Does a representative from the emergency department participate in the prehospital PIPS program? | [ ]  Yes | [ ]  No |  |
| Please describe the process:       |

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|  | **Level** | **Criterion** | **Type** |
| 7(h) | III | If the TMD is not an emergency medicine physician, there must be a designated emergency medicine physician liaison available to the TMD for trauma PIPS issues that occur in the emergency department. As part of the trauma PIPS program, the designated emergency medicine physician liaison must be responsible for all emergency department audits, critiques and mortality review of patients treated in the emergency department. | 2 |
| Is the TMD an emergency medicine physician? | [ ]  Yes | [ ]  No |  |
| If no, provide the name of the emergency medicine physician liaison        |

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|  | **Level** | **Criterion** | **Type** |
| 7(i) | III | Emergency medicine physicians must participate actively in the overall trauma PIPS program and the multidisciplinary trauma peer review committee. | 2 |
| Do the emergency medicine physicians participate actively in the trauma PIPS program? | [ ]  Yes | [ ]  No |  |
| Please describe participation:       |

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|  | **Level** | **Criterion** | **Type** |
| 7(j) | III | Physicians who are licensed to practice medicine who treat trauma patients in the emergency department must be current in ATLS unless the physician is board-certified in emergency medicine. APPs/midlevel providers who participate in the initial evaluation of trauma patients must be current in ATLS. For Level IV TCFs, this may be fulfilled by the Comprehensive Advanced Life Support program if the program includes the mobile trauma module skills station and the provider is re-verified every four years. The Rural Trauma Team Development Course does not fulfill this requirement. | 2 |
| Are all physicians, not board-certified in emergency medicine, current in ATLS? | [ ]  Yes | [ ]  No |  |
| Are all APPs/ midlevel providers current in ATLS? | [ ]  Yes | [ ]  No |  |
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|  | **Level** | **Criterion** | **Type** |
| 7(k) | III  | All board-certified emergency medicine physicians or those eligible for certification by an appropriate emergency medicine board according to current requirements must have successfully completed the ATLS course at least once. | 2 |
| Have all board-certified, or board-eligible, emergency medicine physicians successfully completed the ATLS course at least once? | [ ]  Yes | [ ]  No |  |

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| **8 - Clinical Functions: Neurosurgery** |

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|  | **Level** | **Criterion** | **Type** |
| 8(a) | III if the TCF provides neurosurgery for trauma patients | The TCF must have a formal and published contingency plan for times in which a neurosurgeon is encumbered upon the arrival of a neuro-trauma case. The contingency plan must include:(1) A credentialing process to allow the trauma surgeon to provide initial evaluation and stabilization of a neuro-trauma patient.(2) A requirement for direct contact with the accepting facility to arrange for expeditious transfer or ongoing monitoring support.(3) A review process through the trauma PIPS program to monitor the efficacy of the plan and process.The TCF, in conjunction with a higher level classification TCF, maydefine the non-survivable injury patient who can be kept at the facility and transmitted to palliative care. | 2 |
| Does this TCF provide neurosurgery care for trauma patients? | [ ]  Yes | [ ]  No |  |
| Is there a formal, published contingency plan for times in which a neurosurgeon is encumbered upon arrival of a neuro-trauma case? | [ ]  Yes | [ ]  No | [ ] N/A |
| The contingency plan must include the following: |
| A credentialing process to allow the trauma surgeon to provide initial evaluation and stabilization of a neuro trauma patient. | [ ]  Yes | [ ]  No | [ ] N/A |
| Direct contact with the accepting facility to arrange for expeditious transfer or ongoing monitoring support.  | [ ]  Yes | [ ]  No | [ ] N/A |
| Monitoring of the efficacy of the process by the PIPS program. | [ ]  Yes | [ ]  No | [ ] N/A |

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|  | **Level** | **Criterion** | **Type** |
| 8(b) | III if the TCF provides neurosurgery for trauma patients | If one neurosurgeon covers more than one TCF, each TCF must have a published back-up schedule. The back-up schedule may include calling a back-up neurosurgeon, guidelines for transfer or both. The trauma PIPS program must demonstrate that appropriate and timely care is provided when the back-up schedule must be used. | 2 |
| Does the neurosurgeon cover more than one facility? | [ ]  Yes | [ ]  No | [ ] N/A |
| If a neurosurgeon covers more than one facility, please describe the plan:       |

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|  | **Level** | **Criterion** | **Type** |
| 8(c) | III | The TCF must have a written policy or guideline approved by the TMD that defines which types of patients require a response by neurosurgery and which type of neurosurgical injuries may remain at the TCF and which should be transferred. | 2 |
| Is there a written policy or guideline, approved by the TMD, that defines: |
| Which type of patient require a response by neurosurgery? | [ ]  Yes | [ ]  No |  |
| Which type of neurosurgical injuries may remain at the TCF and which should be transferred? | [ ]  Yes | [ ]  No |  |

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|  | **Level** | **Criterion** | **Type** |
| 8(d) | III | If a TCF does not have neurosurgical coverage, all patients requiring ICP monitoring and patients with significant traumatic brain injuries should be transferred to a higher level TCF. If the TCF does not transfer the patient with a traumatic brain injury, the scope of practice and care of the patient must be outlined in a written guideline or policy. | 2 |
| Are patients with significant traumatic brain injuries transferred to a higher level trauma care facility? | [ ]  Yes | [ ]  No |  |
| If not transferred, is there a written guideline or policy that defines scope of practice and care of the patient with traumatic brain injury? | [ ]  Yes | [ ]  No |  |

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|  | **Level** | **Criterion** | **Type** |
| 8(e) | III | For all neurosurgical cases, whether patients are admitted or transferred, care must be timely and appropriate. | 1 |
| Is care for all neurotrauma patients timely and appropriate? | [ ]  Yes | [ ]  No |  |

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|  | **Level** | **Criterion** | **Type** |
| 8(f) | III | If a TCF provides neurosurgical services, neurosurgery must be part of the trauma PIPS program. | 1 |
| Is the neurosurgeon involved in the trauma PIPS program? | [ ]  Yes | [ ]  No | [ ] N/A |

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|  | **Level** | **Criterion** | **Type** |
| 8(g) | III if the TCF provides neurosurgery for trauma patients | For neurosurgical cases, the trauma PIPS program must:(1) Monitor all patients admitted or transferred.(2) Review all cases requiring backup to be called in or the patient to be diverted or transferred because of the unavailability of the neurosurgeon on call.(3) Monitor the 30 minute response time for the neurosurgeon onceconsulted. | 1 |
| Does the trauma PIPS program: |
| Monitor all patients admitted or transferred? | [ ]  Yes | [ ]  No | [ ] N/A |
| Review all cases requiring backup to be called in or the patient to be diverted or transferred because of the unavailability of the neurosurgeon on call? | [ ]  Yes | [ ]  No | [ ] N/A |
| Monitor the 30 minute response time for the neurosurgeon once consulted? | [ ]  Yes | [ ]  No | [ ] N/A |

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|  | **Level** | **Criterion** | **Type** |
| 8(h) | III if the TCF provides neurosurgery for trauma patients | Neurosurgeons must meet one of the following set of standards in order to take trauma call:(1) Be board certified by an appropriate neurosurgical board.(2) Be eligible for board certification by an appropriate neurosurgicalboard.(3) Meet the neurosurgery alternate pathway requirements; or(4) Have completed an Accreditation Council for Graduate Medical Education or Canadian residency and be recognized by a major professional organization.Note: An example of recognition by a major professional organization is being a fellow of the ACS. | 2 |
| Do all neurosurgeons meet one of the requirements as listed above? | [ ]  Yes | [ ]  No | [ ] N/A |

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|  | **Level** | **Criterion** | **Type** |
| 8(i) | III if the TCF provides neurosurgery for trauma patients | The alternate pathway requirements for neurosurgeons are:(1) Completion of a residency training program in neurosurgery, with the time period consistent with years of training in the United States. The completion of a residency training program must be evidenced by a certified letter from the program director.(2) Current certification as a provider or instructor of the ATLS program.(3) Completion of 36 hours of trauma continuing medical education within the last three years.(4) Attendance at educational meetings and at least 50% of all trauma PIPS meetings in the past three years.(5) Membership or attendance at local and regional or national meetings during the past three years.(6) Provision of a list of patients treated in the last three years with accompanying Injury Severity Score and outcome data.(7) Completion of a performance improvement assessment by the TMD demonstrating that the morbidity and mortality results for patients treated by the surgeon compare favorably with comparable patients treated by other members of the call panel.(8) License to practice medicine and approval for full and unrestricted surgical privileges by the facility’s credentialing committee. | 2 |
| Are any of the neurosurgeons on the alternate pathway? | [ ]  Yes | [ ]  No | [ ] N/A |
| If yes, are all requirements met as listed above? | [ ]  Yes | [ ]  No |  |

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| **9 - Clinical Functions: Orthopedic Surgery** |

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|  | **Level** | **Criterion** | **Type** |
| 9(a) | III | The TCF must have orthopedic surgery capability.  | 1 |
| Does this level III facility have orthopedic surgery capability? | [ ]  Yes | [ ]  No |  |

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|  | **Level** | **Criterion** | **Type** |
| 9(b) | III | An operating room must be adequately staffed, with at least an operating room nurse and operating room technician, and available within 30 minutes of operating room team request for emergency operations on musculoskeletal injuries. | 1 |
| Is an operating room nurse and technician available within 30 minutes of the request for emergency operations on musculoskeletal injuries? | [ ]  Yes | [ ]  No |  |

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|  | **Level** | **Criterion** | **Type** |
| 9(c) | III | The TCF must have an orthopedic surgeon who is identified as the liaison to the trauma program. | 1 |
| Is there an orthopedic surgeon identified as the trauma program liaison? | [ ]  Yes | [ ]  No |  |
| Name of the surgeon:       |

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|  | **Level** | **Criterion** | **Type** |
| 9(d) | III | TCFs must have an orthopedic surgeon on call and promptly available 24 hours a day. | 2 |
| Is there an orthopedic surgeon on call 24/7? | [ ]  Yes | [ ]  No |  |

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|  | **Level** | **Criterion** | **Type** |
| 9(e) | III | A TCF must include orthopedic surgery as part of the trauma PIPS program. | 1 |
| Is orthopedic surgery part of the trauma PIPS program? | [ ]  Yes | [ ]  No |  |

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|  | **Level** | **Criterion** | **Type** |
| 9(f) | III | If the orthopedic surgeon is not dedicated to a single facility or is unavailable while on call, the TCF must have a published back-up schedule. The back-up schedule may include calling a back-up orthopedic surgeon or guidelines for transfer or both. | 2 |
| Is the orthopedic surgeon dedicated to your facility? | [ ]  Yes | [ ]  No |  |
| Is there a published back up schedule or guidelines for transfer, or both, if the orthopedic surgeon is not available? | [ ]  Yes | [ ]  No |  |

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|  | **Level** | **Criterion** | **Type** |
| 9(g) | III | As part of the trauma PIPS program, the TCF must review all major orthopedic trauma cases for appropriateness of the decision to transfer or admit. The TCF must define the scope of practice and indicators for patients that will be admitted. | 2 |
| Are all major orthopedic trauma cases reviewed for appropriateness of the decision to transfer or admit? | [ ]  Yes | [ ]  No |  |
| For patients being admitted, is there a defined scope of practice and indicators for admission? | [ ]  Yes | [ ]  No |  |

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|  | **Level** | **Criterion** | **Type** |
| 9(h) | III | Orthopedic surgeons must meet one of the following set of standards in order to take trauma call:(1) Be board certified in orthopedic surgery.(2) Be eligible for board certification by the appropriate orthopedic specialty board according to current criteria.(3) Meet the orthopedic surgery alternate pathway requirements; or(4) Have completed an Accreditation Council for Graduate Medical Education or Canadian residency and be recognized by a major professional organization.Note: An example of recognition by a major professional organization is being a fellow of the ACS. | 2 |
| Do all orthopedic surgeons meet one of the requirements as listed above? | [ ]  Yes | [ ]  No |  |

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|  | **Level** | **Criterion** | **Type** |
| 9(i) | III | The alternate pathway requirements for orthopedic surgeons are:(1) Completion of a residency training program in orthopedic surgery, with the time period consistent with years of training in the United States. The completion of a residency training program must be evidenced by a certified letter from the program director.(2) Current certification as a provider or instructor of the ATLS program.(3) Completion of 36 hours of trauma continuing medical education within the last three years.(4) Attendance at educational meetings and at least 50% of all trauma PIPS meetings in the past three years.(5) Membership or attendance at local and regional or national meetings during the past three years.(6) Provision of a list of patients treated in the last three years with accompanying Injury Severity Score and outcome data.(7) Completion of a performance improvement assessment by the TMD demonstrating that the morbidity and mortality results for patients treated by the surgeon compare favorably with comparable patients treated by other members of the call panel.(8) License to practice medicine and approval for full and unrestricted surgical privileges by the facility’s credentialing committee. | 2 |
| Are any of the orthopedic surgeons on the alternate pathway? | [ ]  Yes | [ ]  No |  |
| If yes, are all requirements met as listed above? | [ ]  Yes | [ ]  No |  |

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| **10 - Pediatric Trauma Care** |

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|  | **Level** | **Criterion** | **Type** |
| 10(a) | III | A TCF that stabilizes pediatric trauma patients in the emergency department must have guidelines to assure appropriate and safe care of children. A TCF’s pediatric trauma guidelines must include:(1) Child maltreatment assessment, treatment or transfer and reporting protocols including a list of indicators of possible physical abuse.(2) Imaging guidelines, including age and weight-based criteria based on as low as reasonably achievable guidelines.(3) A system to assure appropriate sizing and dosing of resuscitation equipment and medications.(4) Dosing guidelines for intubation, code and neurologic drugs.(5) Guidelines for administration of sedation. | 2 |
| Do you have the following guidelines: |
| Child maltreatment guideline including assessment, treatment or transfer, reporting and list of possible indicators of abuse. | [ ]  Yes | [ ]  No |  |
| Imaging guidelines including age and weight-based criteria. | [ ]  Yes | [ ]  No |  |
| A system to assure appropriate sizing and dosing of resuscitation equipment and medication.  | [ ]  Yes | [ ]  No |  |
| Guidelines for administration of sedation. | [ ]  Yes | [ ]  No |  |

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|  | **Level** | **Criterion** | **Type** |
| 10(b) | III | A TCF that stabilizes pediatric trauma patients in the emergency department must have the following medications and equipment:(1) Mannitol or 3% saline.(2) Intubation, code and neurologic medications.(3) Catheter-over-the-needle device; 22 and 24 gauge.(4) Pediatric intraosseous needles or device.(5) Intravenous solutions including the following: normal saline and dextrose 5% normal saline.(6) Infant and child c-collars.(7) Cuffed endotracheal tubes: 3.5, 4.5, 5.5, and 6.5 millimeters.(8) Laryngoscope: Straight: 1, Straight: 2, and Curved: 2.(9) Infant and child nasopharyngeal airways.(10) Oropharyngeal airways, sizes 0,1,2,3 and 4.(11) Pediatric stylets for endotracheal tubes.(12) Infant and child suction catheters.(13) Bag-mask device, self-inflating: infant: 450 milliliters.(14) Masks to fit bag-mask device adaptor for infants and children.(15) Clear oxygen masks: partial non-breather infant and partial nonbreather child.(16) Infant and child nasal cannulas.(17) Nasogastric tubes: Infant: 8 French size and child: 10 French size.(18) Laryngeal mask airway: sizes 1.5, 2, 2.5, and 3.(19) Chest tubes: Infant: 10 or 12 French size and Child: one in the 16-24 French size range. | 2 |
| Do you have each of the above medications and equipment? | [ ]  Yes | [ ]  No |  |
| If no, please describe:       |

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| **11 - Collaborative Clinical Services** |

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|  | **Level** | **Criterion** | **Type** |
| 11(a) | III  | The TCF must have an ICU. An ICU, regardless of whether an area of the facility is actually so designated, is a department or area of a TCF that provides intensive treatment medicine, focuses on patients with severe and life-threatening illness or injuries which require constant and close monitoring and support and is staffed by highly trained doctors and nurses who specialize in caring for critically ill patients. | 1 |
| Do you have an ICU? | [ ]  Yes | [ ]  No |  |
| Is the ICU staffed by highly trained doctors and nurses who specialize in caring for critically ill patients? | [ ]  Yes | [ ]  No |  |
|  | **Level** | **Criterion** | **Type** |
| 11(b) | III  | Anesthesiology services, including anesthesiologists or certified registered nurse anesthetists, must be available within 30 minutes of notification and request for emergency operations, for managing airway problems, and as needed for patient care. | 1 |
| Do you provide anesthesiology services for trauma patients? | [ ]  Yes | [ ]  No |  |
| If yes, is the anesthesiologist or CRNA available within 30 minutes of notification? | [ ]  Yes | [ ]  No |  |
|  | **Level** | **Criterion** | **Type** |
| 11(c) | III | A qualified and dedicated physician anesthesiologist or certified registered nurse anesthetist or a certified anesthesia assistant must be designated as a liaison to the trauma program. | 1 |
| Is an anesthesiologist, CRNA, or certified anesthesia assistant designated as a liaison to the trauma program? | [ ]  Yes | [ ]  No |  |
| If yes, please provide the name of this individual.       |
|  | **Level** | **Criterion** | **Type** |
| 11(d) | III | The anesthesia liaison must participate in the trauma PIPS program.  | 2 |
| Does the anesthesia liaison participate in the trauma PIPS program? | [ ]  Yes | [ ]  No |  |
|  | **Level** | **Criterion** | **Type** |
| 11(e) | III | The TCF must document the availability of anesthesia services and delays in airway control or operations in the trauma PIPS program.  | 2 |
| Are delays in airway control or operation documented in the trauma PIPS program? | [ ]  Yes | [ ]  No |  |
|  | **Level** | **Criterion** | **Type** |
| 11(f) | III | When the anesthesiologist or designee is responding from outside the TCF, during the time between notification of the anesthesia provider and their arrival, a provider must be available for emergency airway management. The presence of a provider skilled in emergency airway management must be documented. | 1 |
| If responding from outside of the organization, is there a provider available for airway management until the anesthesia provider arrives? | [ ]  Yes | [ ]  No | [ ]  N/A |
| What specialty is this provider?       |
|  | **Level** | **Criterion** | **Type** |
| 11(g) | III | An operating room must be adequately staffed, with at least an operating room nurse and operating room technician, and available within 30 minutes of operating room team request. | 1 |
| Is an operating room nurse and technician available within 30 minutes of the request for emergency operations? | [ ]  Yes | [ ]  No |  |
|  | **Level** | **Criterion** | **Type** |
| 11(h) | III | The TCF must monitor the timeliness of starting operations and the instances when operating room personnel including anesthesia support services, post anesthesia care unit personnel are not available for greater than 30 minutes. The TCF must monitor and document through the trauma PIPS program the response times of these personnel. The TCF must identify and review operating room delays involving trauma patients or adverse outcomes for reasons for delay and opportunities for improvement. | 2 |
| Do you monitor the timeliness of starting operations when operating room personnel are not available for greater than 30 minutes? | [ ]  Yes | [ ]  No |  |
| Do you identify and review operating room delays, adverse outcomes for reasons for delay and opportunities for improvement? | [ ]  Yes | [ ]  No |  |
|  | **Level** | **Criterion** | **Type** |
| 11(i) | III | The TCF must have the ability to perform services involving rapid infusers, thermal control equipment and resuscitation fluids, intraoperative radiologic capabilities and equipment for fracture fixation/stabilization. | 1 |
| Do you have the ability to perform the following services intraoperatively: |
| Rapid infusers | [ ]  Yes | [ ]  No |  |
| Thermal control equipment | [ ]  Yes | [ ]  No |  |
| Resuscitation fluids | [ ]  Yes | [ ]  No |  |
| Radiologic capabilities | [ ]  Yes | [ ]  No |  |
| Equipment for fracture fixation/ stabilization | [ ]  Yes | [ ]  No |  |
|  | **Level** | **Criterion** | **Type** |
| 11(j) | III | If a TCF provides neurosurgical services, the TCF must have the necessary equipment to perform a craniotomy. | 1 |
| Do you have the necessary equipment to perform a craniotomy? | [ ]  Yes | [ ]  No | [ ]  N/A |
|  | **Level** | **Criterion** | **Type** |
| 11(k) | III | Post anesthesia services, including qualified nurses, must be available 24 hours per day to provide care for the patient if needed during the recovery phase. | 1 |
| Are all post anesthesia services, including qualified nurses, available 24 hours per day to provide care during the recovery phase? | [ ]  Yes | [ ]  No |  |
|  | **Level** | **Criterion** | **Type** |
| 11(km) | III | In the delivery of post anesthesia care, providers must have the necessary equipment to monitor and resuscitate patients, consistent with the process of care designated by the facility. | 1 |
| Does the facility have the necessary equipment to monitor and resuscitate patients in the post-operative phase of care? | [ ]  Yes | [ ]  No |  |
|  | **Level** | **Criterion** | **Type** |
| 11(l) | III | The TCF’s trauma PIPS program must address the need for pulse oximetry, end-tidal carbon dioxide detection, arterial pressure monitoring, patient rewarming and intracranial pressure monitoring. | 2 |
| Does the trauma PIPS program address the need for: |
| Pulse oximetry  | [ ]  Yes | [ ]  No |  |
| End-tidal carbon dioxide detection | [ ]  Yes | [ ]  No |  |
| Arterial pressure monitoring | [ ]  Yes | [ ]  No |  |
| Patient rewarming | [ ]  Yes | [ ]  No |  |
| Intracranial pressure monitoring (neurosurgical cases) | [ ]  Yes | [ ]  No | [ ]  N/A |
|  | **Level** | **Criterion** | **Type** |
| 11(lm) | III | A TCF must 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. | 2 |
| Do you have a policy to assure that trauma patients are accompanied by appropriately trained providers during transportation to, and while in, the radiology department? | [ ]  Yes | [ ]  No |  |
|  | **Level** | **Criterion** | **Type** |
| 11(m) | III | Conventional radiology must be available 24 hours per day. The radiology technician does not need to be in-house 24 hours per day but must respond within 30 minutes of notification. | 1 |
| Is a conventional radiology technician in-house 24 hours/ day? | [ ]  Yes | [ ]  No |  |
| If no, does the technician respond within 30 minutes of notification? | [ ]  Yes | [ ]  No |  |
|  | **Level** | **Criterion** | **Type** |
| 11(mm) | III | CT must be available 24 hours per day. The CT technologist does not need to be in-house 24 hours per day but must respond within 30 minutes of notification. | 1 |
| Is a CT technologist in-house 24 hours/ day? | [ ]  Yes | [ ]  No |  |
| If no, does the technologist respond within 30 minutes of notification? | [ ]  Yes | [ ]  No |  |
|  | **Level** | **Criterion** | **Type** |
| 11(n) | III | If a CT technologist takes a call from outside the facility, the TCF’s trauma PIPS program must document the CT technologist’s time of arrival at the facility. | 2 |
| If the CT technologist takes call from outside the facility, does the trauma PIPS program document the time of arrival at the facility? | [ ]  Yes | [ ]  No | [ ]  N/A |
|  | **Level** | **Criterion** | **Type** |
| 11(nm) | III | For TCFs with MRI capabilities, the MRI technologist may respond from outside the hospital. The trauma PIPS program must document and review arrival of the MRI technologist within one hour of being called. | 2 |
| Does the facility have MRI capabilities for trauma? | [ ]  Yes | [ ]  No |  |
| If yes, does the trauma PIPS program document and review arrival of the MRI technologist within one hour of being called? | [ ]  Yes | [ ]  No | [ ]  N/A |
|  | **Level** | **Criterion** | **Type** |
| 11(o) | III | Qualified radiologists must be available within 30 minutes of notification, in person or by tele-radiology, to interpret radiographs. | 1 |
| Is a qualified radiologist available within 30 minutes of notification? | [ ]  Yes | [ ]  No |  |
| Please explain process:       |
|  | **Level** | **Criterion** | **Type** |
| 11(om) | III | Radiological diagnostic information must be communicated in a timely manner in either written or electronic form. | 2 |
| Are radiology results communicated in a timely manner? | [ ]  Yes | [ ]  No |  |
| Please explain process:       |
|   | **Level** | **Criterion** | **Type** |
| 11(p) | III | Critical radiology information deemed to immediately affect patient care must be verbally communicated to the trauma team in a timely manner. | 2 |
| Are critical results verbally communicated to the trauma team in a timely manner? | [ ]  Yes | [ ]  No |  |
|  | **Level** | **Criterion** | **Type** |
| 11(pm) | III | The final radiology report must accurately reflect the chronology and context of communications with the trauma team, including changes between the preliminary and final interpretations. The TCF must have a written over-read process that defines how changes in interpretation are documented and communicated. | 2 |
| Does the final radiology report accurately reflect the chronology and context of communications with the trauma team? | [ ]  Yes | [ ]  No |  |
| Is there a written over-read process that defines how changes in interpretation are documented and communicated? | [ ]  Yes | [ ]  No |  |
|  | **Level** | **Criterion** | **Type** |
| 11(q) | III | The TCF must monitor changes in interpretation between the preliminary and final radiology reports, as well as missed injuries, through the trauma PIPS program. | 2 |
| Are changes in interpretation between preliminary and final radiology reports, and missed injuries, monitored through the trauma PIPS program? | [ ]  Yes | [ ]  No |  |
|  | **Level** | **Criterion** | **Type** |
| 11(qm) | III | A surgeon on the trauma call panel must be actively involved in andresponsible for setting policies and making administrative decisionsrelated to trauma ICU patients. This may be a TMD who is a surgeon. | 2 |
| Is there a surgeon on the trauma call panel that is actively involved in and responsible for setting policies and making administration decisions related to trauma ICU patients? | [ ]  Yes | [ ]  No |  |
| If yes, please provide the name of the surgeon.       |
|  | **Level** | **Criterion** | **Type** |
| 11(r) | III | The TCF must have physician coverage of the ICU available within 30 minutes and have a formal plan in place for emergency coverage. A TCF must track physician response time as part of the trauma PIPS program. Physician coverage of the ICU does not replace the primary surgeon but instead ensures that the patient’s immediate needs are met while the primary surgeon is being contacted. | 1 |
| Is there physician coverage of the ICU available within 30 minutes? | [ ]  Yes | [ ]  No |  |
| Is response time tracked as part of the trauma PIPS program? | [ ]  Yes | [ ]  No |  |
| Is there a formal plan in place for emergency coverage? | [ ]  Yes | [ ]  No |  |
| Please describe the plan:       |
|  | **Level** | **Criterion** | **Type** |
| 11(rm) | III | The TCF’s trauma PIPS program must review all ICU trauma admissions and transfers of ICU patients to ensure that appropriate patients are being selected to remain at the TCF versus being transferred to a higher level of care. The TCF must have a written guideline that defines which types of ICU patients they will admit and which they will transfer to a higher level of care. | 2 |
| Is there a written guideline that defines which types of ICU patients will be admitted and those that are transferred to a higher level of care?  | [ ]  Yes | [ ]  No |  |
| Are all ICU trauma admissions and transfers of ICU patients reviewed by the trauma PIPS program to ensure that appropriate patients are selected to remain at your hospital versus being transferred to a higher level of care?  | [ ]  Yes | [ ]  No |  |
|  | **Level** | **Criterion** | **Type** |
| 11(s) | III | In a TCF, the trauma surgeon must retain responsibility for and coordinate all therapeutic decisions of trauma ICU patients. Many of thedaily care requirements can be collaboratively managed by a dedicatedICU team, but the trauma surgeon must be kept informed and concur with major therapeutic and management decisions made by the ICU team. | 1 |
| Does the trauma surgeon retain responsibility for and coordinate therapeutic decisions of trauma ICU patients? | [ ]  Yes | [ ]  No |  |
| Please explain the facility’s process:       |
|  | **Level** | **Criterion** | **Type** |
| 11(sm) | III | The TCF’s trauma PIPS program must document that timely and appropriate ICU care and coverage are being provided for trauma ICU patients. The TCF must continuously monitor the timely response of credentialed providers to the ICU as part of the trauma PIPS program. The TCF’s trauma PIPS program must include quality indicators for the ICU including review of complications. Review of complications includes but is not limited to review of orthopedic and neurosurgical complications if the TCF provides these services. | 2 |
| Does the trauma PIPS program document timely and appropriate ICU care and coverage provided for trauma ICU patients?  | [ ]  Yes | [ ]  No |  |
| Is the timely response of credentialed providers to the ICU monitored by the trauma PIPS program?  | [ ]  Yes | [ ]  No |  |
| Are quality indicators, including review of complications, included in the trauma PIPS program? | [ ]  Yes | [ ]  No |  |
|  | **Level** | **Criterion** | **Type** |
| 11(t) | III | The TCF must have a designated ICU liaison to the trauma service. The liaison must be designated based on the service that provides the majority of the care in the ICU. | 2 |
| Is there a designated ICU liaison to the trauma service? | [ ]  Yes | [ ]  No |  |
| Please provide the name of this liaison.        |
|  | **Level** | **Criterion** | **Type** |
| 11(tm) | III | In the TCF, qualified critical care nurses must be available 24 hours per day to provide care for trauma patients during the ICU phase. The TCF may define who is a qualified critical care nurse based on education and competency standards. | 1 |
| Are qualified critical care nurses available 24 hours per day to provide care for trauma patients in the ICU? | [ ]  Yes | [ ]  No |  |
| Please provide qualifications for the critical care nurse that cares for trauma patients:       |
|  | **Level** | **Criterion** | **Type** |
| 11(u) | III | For trauma patients in the ICU, the TCF must have adequate numbers of licensed registered nurses, licensed practical nurses and other personnel to provide nursing care to all trauma patients in the ICU. | 2 |
| Is there an adequate number of RNs, LPNs, and other personnel to provide care to all trauma patients in the ICU? | [ ]  Yes | [ ]  No |  |
| Please describe the staffing plan:        |
|  | **Level** | **Criterion** | **Type** |
| 11(um) | III | The TCF must have the necessary equipment for the ICU to monitor and resuscitate patients. Each TCF shall determine the equipment necessary based on the types of patients admitted and treated. | 1 |
| Does the facility have the necessary equipment for the ICU to monitor and resuscitate patients? | [ ]  Yes | [ ]  No |  |
|  | **Level** | **Criterion** | **Type** |
| 11(v) | III | If a TCF has neurosurgical coverage and admits neuro-trauma patients, intracranial pressure monitoring equipment must be available. | 1 |
| Is there intracranial pressure monitoring equipment available if there is neurosurgical coverage and the facility admits neuro-trauma patients? | [ ]  Yes | [ ]  No | [ ]  N/A |
|  | **Level** | **Criterion** | **Type** |
| 11(vm) | III | Trauma patients, as defined by the Wisconsin trauma registry inclusion criteria, must not be admitted or transferred by a primary care physician without the knowledge and consent of the trauma service. The TCF’s trauma PIPS program must monitor adherence to this guideline.Note: The Wisconsin trauma registry inclusion criteria are contained within the Wisconsin Trauma Data Dictionary, which is published on the Department’s Trauma webpage:<https://www.dhs.wisconsin.gov/publications/p01117.pdf> | 2 |
| Is the trauma service notified if a patient is transferred to a primary care physician?  | [ ]  Yes | [ ]  No |  |
| Does the trauma PIPS program monitor adherence? | [ ]  Yes | [ ]  No |  |
|  | **Level** | **Criterion** | **Type** |
| 11(w) | III | The TCF must have a respiratory therapist in-house or on call 24 hours a day.  | 1 |
| Is there a respiratory therapist in-house or on call 24 hours a day? | [ ]  Yes | [ ]  No |  |
|  | **Level** | **Criterion** | **Type** |
| 11(wm) | III | The TCF must have laboratory services available 24 hours per day for the standard analysis of blood, urine and other body fluids, including microsampling when appropriate.  | 1 |
| Are lab services available 24 hours/ day? | [ ]  Yes | [ ]  No |  |
|  | **Level** | **Criterion** | **Type** |
| 11(x) | III | The TCF’s blood bank must be capable of blood typing and crossmatching. | 1 |
| Is the facility’s blood bank capable of blood typing and crossmatching? | [ ]  Yes | [ ]  No |  |
|  | **Level** | **Criterion** | **Type** |
| 11(xm) | III | The TCF’s blood bank must have an adequate supply of packed red blood cells and fresh frozen plasma available within 15 minutes.  | 1 |
| Is there an adequate supply of packed red blood cells and fresh frozen plasma available within 15 minutes? | [ ]  Yes | [ ]  No |  |
|  | **Level** | **Criterion** | **Type** |
| 11(y) | III | TCFs must have a massive transfusion protocol that is developed collaboratively with the trauma service and blood bank. | 1 |
| Does the facility have a massive transfusion protocol that has been developed collaboratively with the trauma service and blood bank? | [ ]  Yes | [ ]  No |  |
|  | **Level** | **Criterion** | **Type** |
| 11(ym) | III | The TCF must have coagulation studies, blood gas analysis and microbiology studies available 24 hours per day. | 1 |
| Are coagulation studies, blood gas analysis and microbiology studies available 24 hours per day? | [ ]  Yes | [ ]  No |  |
|  | **Level** | **Criterion** | **Type** |
| 11(z) | III | APPs who participate in the initial evaluation of trauma patients must be current in ATLS, except if the APP is accepting a trauma patient as a direct admission.  | 2 |
| Are all APPs, who participate in the initial evaluation of trauma patients current in ATLS? | [ ]  Yes | [ ]  No |  |
|  | **Level** | **Criterion** | **Type** |
| 11(zm) | III | A TCF must have appropriate orientation, credentialing processes and skill maintenance for APPs, as witnessed by an annual review by the TMD. | 2 |
| Is there an appropriate orientation, credentialing processes and skill maintenance for APPs, as witnessed by an annual review by the TMD? | [ ]  Yes | [ ]  No |  |

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| **12 - Rehabilitation** |

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|  | **Level** | **Criterion** | **Type** |
| 12(a) | III | Physical therapy services must be provided in the TCF. | 1 |
| Do you have physical therapy services? | [ ]  Yes | [ ]  No |  |
|  | **Level** | **Criterion** | **Type** |
| 12(b) | III | Social services must be provided in the TCF. | 2 |
| Do you have social services? | [ ]  Yes | [ ]  No |  |

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| **13 - Guidelines for the Operation of Burn Centers** |

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|  | **Level** | **Criterion** | **Type** |
| 13(a) | III | A TCF must have written guidelines, including transfer plans, for the care of burn patients. | 2 |
| Does the facility have written guidelines, including transfer plans, for the care of burn patients? | [ ]  Yes | [ ]  No |  |

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| **14 - Trauma Registry** |

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|  | **Level** | **Criterion** | **Type** |
| 14(a) | III | A TCF must collect and analyze trauma registry data and must submit this data to the department per s. DHS 118.09 (3) (a) & (b). | 2 |
| Do you collect and analyze trauma registry data? | [ ]  Yes | [ ]  No |  |
| Do you submit data to DHS on a quarterly basis? | [ ]  Yes | [ ]  No |  |
|  | **Level** | **Criterion** | **Type** |
| 14(b) | III | The TCF must submit the required data elements, defined by the Wisconsin Trauma Data Dictionary to the Wisconsin trauma registry.Note: The Wisconsin Trauma Data Dictionary is prepared, maintained and updated by the Wisconsin Department of Health Services and is published on the Department’s Trauma webpage:<https://www.dhs.wisconsin.gov/publications/p01117.pdf> | 2 |
| Are all required data elements submitted to the Wisconsin trauma registry? | [ ]  Yes | [ ]  No |  |
|  | **Level** | **Criterion** | **Type** |
| 14(c) | III | A TCF must use trauma registry data to support their trauma PIPS program.  | 2 |
| Do you use trauma registry data to support the trauma PIPS program?  | [ ]  Yes | [ ]  No |  |
| Please provide one example:        |
|  | **Level** | **Criterion** | **Type** |
| 14(d) | III | A TCF must use trauma registry data to identify injury prevention priorities that are appropriate for local implementation. | 2 |
| Do you use trauma registry data to identify injury prevention priorities? | [ ]  Yes | [ ]  No |  |
| Please provide one example:       |
|  | **Level** | **Criterion** | **Type** |
| 14(e) | III | A TCF’s trauma registry must be concurrent. At a minimum, the TCF must enter 80% of cases within 60 days of patient discharge. | 2 |
| At a minimum, does the registry have 80% of cases entered within 60 days of discharge? | [ ]  Yes | [ ]  No |  |
|  | **Level** | **Criterion** | **Type** |
| 14(f) | III | At least one staff trauma registrar at each TCF must either have previously attended the following two courses or attend the following two courses within 12 months of being hired:(1) The American Trauma Society’s two-day, in person trauma registry course or equivalent provided by a state trauma program.(2) The Association of the Advancement of Automotive Medicine’s Abbreviated Injury Scale and Injury Scoring: Uses and Techniques course. | 2 |
| Has at least one staff trauma registrar attended, or will attend, the above 2 courses within 2 years of hire? | [ ]  Yes | [ ]  No |  |
|  | **Level** | **Criterion** | **Type** |
| 14(g) | III | The TCF must ensure that appropriate measures are in place to meet the confidentiality requirements of the trauma registry data. The TCF must protect against threats, hazards and unauthorized uses or disclosures of trauma program data as required by the Health Insurance Portability and Accountability Act and other state and federal laws. Protocols to protect confidentiality, including providing information only to staff members who have a demonstrated need to know, must be integrated in the administration of the TCF’s trauma program. | 2 |
| Does the trauma program ensure that trauma registry confidentiality measures are in place? | [ ]  Yes | [ ]  No |  |
| If “yes”, please explain:       |
|  | **Level** | **Criterion** | **Type** |
| 14(h) | III | The TCF must demonstrate that appropriate staff resources are dedicated to the trauma registry. | 2 |
| Are there appropriate staff resources dedicated to the trauma registry? | [ ]  Yes | [ ]  No |  |
|  | **Level** | **Criterion** | **Type** |
| 14(i) | III | The TCF must have a strategy for monitoring the validity of the data entered into the trauma registry. | 2 |
| Do you have strategies for monitoring data validity? | [ ]  Yes | [ ]  No |  |
|  Please explain process:       |
|  | **Level** | **Criterion** | **Type** |
| 14(j) | III | The TCF must demonstrate that all trauma patients can be identified for review. | 2 |
| Are you able assure that all trauma patients can be identified for review? | [ ]  Yes | [ ]  No |  |
| Please explain process:       |
|  | **Level** | **Criterion** | **Type** |
| 14(k) | III | The TCF’s trauma PIPS program must be supported by a reliable method of data collection that consistently obtains the information necessary to identify opportunities for improvement. | 2 |
| Does the trauma registry support the PI process and assist in identifying opportunities for improvement? | [ ]  Yes | [ ]  No |  |

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| **15 - Performance Improvement and Patient Safety** |

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|  | **Level** | **Criterion** | **Type** |
| 15(a) | III | The TCF must have a trauma PIPS program that includes a comprehensive written plan outlining the configuration and identifying both adequate personnel to implement that plan and an operational data management system. | 2 |
| Do you have a performance improvement program that includes a comprehensive written plan outlining the configuration and identifying both adequate personnel to implement the plan and an operation data management system? | [ ]  Yes | [ ]  No |  |
|  | **Level** | **Criterion** | **Type** |
| 15(b) | III | The TCF’s loop closure including problem resolution, outcome improvements and assurance of safety must be readily identifiable through methods of monitoring, re-evaluation, benchmarking and documentation. | 2 |
| Please provide a minimum of two PI problems that you identified and the loop closure (resolution) achieved along with who was responsible for the system and/or peer review issues (ideally one peer review and one systems issue) May be attached instead of documented here, if attached, please enter to document name here:       |
|  | **Level** | **Criterion** | **Type** |
| 15(c) | III | The TCF’s trauma PIPS program must integrate with the facility quality and patient safety efforts and have a clearly defined reporting structure and method for the integration of feedback. | 2 |
| Does the trauma PIPS program integrate with the hospital quality and patient safety effort and have a clearly defined reporting structure and method for the integration of feedback?  | [ ]  Yes | [ ]  No |  |
|  | **Level** | **Criterion** | **Type** |
| 15(d) | III | The TCF must use clinical practice guidelines, protocols and algorithms derived from evidence-based validated resources to help reduce unnecessary variation in the care they provide. | 2 |
| Does the trauma program use clinical practice guidelines, protocols and algorithms derived from evidence-based validated resources (TQIP, EAST, or Western Trauma Association)? | [ ]  Yes | [ ]  No |  |
|  | **Level** | **Criterion** | **Type** |
| 15(e) | III | The TCF must document, in the trauma PIPS program written plan, all process and outcome measures. At least annually, the TCF must review and update all process and outcome measures. | 2 |
| Are all process and outcome measures documented within the trauma PI program’s written plan reviewed and updated at least annually? | [ ]  Yes | [ ]  No |  |
| Your facilities written PIPS plan should be enter here or it may be attached instead of documented here, if attached, please enter to document name here:       |
|  | **Level** | **Criterion** | **Type** |
| 15(f) | III | The TCF must systematically review all trauma-related mortalities from point of injury to death and identify mortalities with opportunities for improvement for the multidisciplinary trauma peer review committee. | 2 |
| Are all trauma-related mortalities systematically reviewed and those mortalities with opportunity for improvement identified for multidisciplinary review? | [ ]  Yes | [ ]  No |  |
| Are all trauma-related mortalities classified as anticipated with opportunity for improvement, anticipated with no opportunity for improvement or unanticipated with opportunity for improvement? | [ ]  Yes | [ ]  No |  |
|  | **Level** | **Criterion** | **Type** |
| 15(g) | III | The TCF must have sufficient mechanisms available to identify events for review by the trauma PIPS program. Once an event is identified, the trauma PIPS program must be able to verify and validate that event. | 2 |
| Are there sufficient mechanisms available to identify events for review by the trauma PI program? | [ ]  Yes | [ ]  No |  |
| Describe how these events are verified and validated through the PI process:       |
|  | **Level** | **Criterion** | **Type** |
| 15(h) | III | The TCF must have a process to address trauma program operational events including system process related events and, when appropriate, the analysis and proposed corrective action. The TCF must have documentation that reflects the review of operational events, and when appropriate, the analysis and proposed corrective action. | 2 |
| Is there a process to address trauma program operational events and, when appropriate, the analysis and proposed corrective action? | [ ]  Yes | [ ]  No |  |
| Please describe this process:       |
|  | **Level** | **Criterion** | **Type** |
| 15(i) | III | When the TCF identifies an opportunity for improvement, appropriate corrective actions to mitigate or prevent similar future adverse events must be developed, implemented and clearly documented by the trauma PIPS program. | 2 |
| When an opportunity for improvement is identified, are corrective actions to mitigate or prevent similar future adverse events developed, implemented and clearly documented by the trauma PIPS program? | [ ]  Yes | [ ]  No |  |
|  | **Level** | **Criterion** | **Type** |
| 15(j) | III | When a general surgeon cannot attend the trauma multidisciplinary peer review meeting, the TMD must ensure that the general surgeon receives and acknowledges receipt of critical information generated at the meeting. | 2 |
| Does the trauma medical director ensure and document dissemination of information and findings from the trauma multidisciplinary peer review meetings to general surgeons who were unable to attend? | [ ]  Yes | [ ]  No |  |
| Please describe process:       |

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| **16 - Outreach and Education** |

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|  | **Level** | **Criterion** | **Type** |
| 16(a) | III | The TCF must engage in public and professional education, including participation in prehospital education. | 2 |
| Are you engaged in public and professional education, including prehospital education? | [ ]  Yes | [ ]  No |  |
| Please describe:       |
|  | **Level** | **Criterion** | **Type** |
| 16(b) | III | The TCF must provide trauma-related education for nurses involved in trauma care. | 2 |
| Do you provide trauma-related education for nurses involved in trauma care? | [ ]  Yes | [ ]  No |  |
| Check the certifications below that nursing staff has obtained: |
| Trauma Nursing Core Course (TNCC) | [ ]  Yes | [ ]  No |  |
| Advanced Trauma Care for Nurses (ATCN) | [ ]  Yes | [ ]  No |  |
| Emergency Nursing Pediatric Course (ENPC) | [ ]  Yes | [ ]  No |  |
| Trauma Care After Resuscitation (TCAR) | [ ]  Yes | [ ]  No |  |
| Certified Emergency Nurse (CEN) | [ ]  Yes | [ ]  No |  |
| Other       | [ ]  Yes | [ ]  No |  |

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| **17 - Prevention** |

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|  | **Level** | **Criterion** | **Type** |
| 17(a) | III | The TCF must have an organized and effective approach to injury prevention and must prioritize these efforts based on local trauma registry and epidemiologic data. | 2 |
| Is there an injury prevention/ public trauma education program based on local trauma registry and epidemiologic data? | [ ]  Yes | [ ]  No |  |
|  | **Level** | **Criterion** | **Type** |
| 17(b) | III | The TCF must have someone in a leadership position that has injury prevention as part of his or her job description. | 2 |
| Do you have someone in a leadership position that has injury prevention as part of his or her job description? | [ ]  Yes | [ ]  No |  |
|  | **Level** | **Criterion** | **Type** |
| 17(c) | III | Universal screening for alcohol use must be performed and documented for all injured patients over 12 years of age. This screening must be done on patients admitted or discharged from the emergency department, but not those transferred to a higher level of care. | 2 |
| Is universal screening for alcohol use performed and documented for all injured patients over 12 years of age on patients that are admitted or discharged from the emergency department? | [ ]  Yes | [ ]  No |  |

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| **18 - Disaster Planning and Management** |

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|  | **Level** | **Criterion** | **Type** |
| 18(a) | III | The TCF must meet the disaster-related requirements of the Joint Commission or other accrediting bodies. | 2 |
| Do you meet the disaster-related requirement of the Joint Commission or other accrediting bodies? | [ ]  Yes | [ ]  No |  |
|  | **Level** | **Criterion** | **Type** |
| 18(b) | III | A liaison from the trauma program must be a member of the TCF’sdisaster committee | 2 |
| Who from the trauma program is a member of your hospital disaster committee?       |
|  | **Level** | **Criterion** | **Type** |
| 18(c) | III | The TCF must participate in regional disaster management plans and exercises. | 2 |
| Do you participate in regional disaster management plans and exercises? | [ ]  Yes | [ ]  No |  |

**Emergency Physicians and Advance Practice Providers**

Please list all emergency physicians and advanced practice providers (Physician Assistants, Nurse Practitioners, and Advance Practice Nurses) currently participating in the activation and initial resuscitation of trauma patients.

| **Name** | **Credentials****(i.e. MD, DO, PA, NP, APN)** | **Board Certified****(Physician Specialty) (i.e.ED, FM, IM)** | **ATLS Current (Exp. Date)** | **ATLS Taken Once****(Exp. Date)** | **No ATLS Course Taken (Check)** | **Alternate Pathway\*****(Check)** |
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\*Emergency physicians who have trained outside the United States or Canada may be eligible to participate in the trauma program through an alternate pathway procedure.

**Trauma/ General Surgeons**

| **Name** | **Board Certification****S=American Board of Surgery****OS= Osteopathic Surgery****CC=Critical Care****PS= Pediatric Surgery** | **Frequency of trauma call per month (days)** | **Number of trauma patients admitted per year** | **Number of trauma operative cases/ year** | **Number of trauma patients admitted per year with ISS>15** | **Percentage of time the surgeon arrival was within 30 minutes of patient arrival** | **ATLS taken at least once****(Exp date)** | **ATLS Current****(Check)** | **Alternate Pathway\*****(Check)** |
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\*General Surgeons who have trained outside the United States or Canada may be eligible to participate in the trauma program through an alternate pathway procedure.

**Orthopedic Surgery**

| **Name** | **Board Certification****(Check)** | **Frequency of trauma call/ month (days)** | **Number of trauma operative cases per year** | **Alternate Pathway\*****(Check)** |
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\*Orthopedic Surgeons who have trained outside the United States or Canada may be eligible to participate in the trauma program through an alternate pathway procedure.

**Neurosurgery**

| **Name** | **Board Certification****(check)** | **Frequency of trauma call/ month (days)** | **Number of trauma operative cases per year** | **Number of trauma craniotomies per year** | **Alternate Pathway\*****(check)** |
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\*Neurosurgeons who have trained outside the United States or Canada may be eligible to participate in the trauma program through an alternate pathway procedure.